Supreme Court, U.S.
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No. 05-____

IN THE
Supreme Court of the United States

TELECARE CORP.,
Petitioner,

v.

MIKE LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF HEALTH AND HUMAN SERVICES; and CENTER FOR MEDICARE AND MEDICAID SERVICES,
Respondents.

On Petition for Writ of Certiorari
to the Court of Appeals for the Federal Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Since 1980, the Social Security Act has provided that when a person both has private health insurance and is eligible for Medicare, Medicare is a "secondary payer" of medical expenses. That is, Medicare is required to pay for only those expenses that the individual's health insurance plan does not cover. If Medicare nevertheless pays for expenses that the private plan should have covered, the federal government may demand reimbursement under 42 U.S.C. § 1395y(b)(2)(B)(iii) from any entity that is "responsible" for covering them under the private plan.

The question presented is:

Whether an entity that neither has contractually agreed to cover an individual's medical bills nor is contractually indemnified by an entity that has so agreed is "responsible" to pay for the individual's medical expenses under 42 U.S.C. § 1395y(b)(2)(B)(iii).

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6, Petitioner states that no parent or publicly held corporation owns 10 percent or more of the stock of Telecare Corp.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Telecare Corp. respectfully petitions for a writ of certiorari to the United States Court of Appeals for the Federal Circuit in *Telecare Corp. v. Leavitt*, No. 04-1389.

OPINIONS BELOW

The opinion of the Federal Circuit is reported at 409 F.3d 1345 (Fed. Cir. 2005), and is reprinted at App. 1a-12a. The district court's order is unpublished and is reprinted at App. 22a-30a.

STATEMENT OF JURISDICTION

The Court of Appeals for the Federal Circuit issued its opinion upholding the dismissal of Petitioner's complaint on May 25, 2005. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions of the Social Security Act are reproduced at App. 31a-45a.

STATEMENT OF THE CASE

A. The Medicare Secondary Payer (MSP) Program

Medicare is a government-funded health insurance program operating primarily under Title 18 of the Social Security Act, 42 U.S.C. § 1395, *et seq.* It is administered by the Center for Medicare and Medicaid Services (CMS). Medicare pays for medical "items and services" that doctors, hospitals, and other health care providers supply to Medicare beneficiaries. 42 U.S.C. §§ 1395d, 1395k. Medicare beneficiaries are the elderly, disabled, or others who meet certain defined criteria. 42 U.S.C. § 1395c.

Originally, Medicare paid for medical items and services "without regard to whether they were also covered by an employer group health plan." *New York Life Ins. Co. v. United States*, 190 F.3d 1372, 1373 (Fed. Cir. 1999) (quoting *Health Ins. Ass'n of Am. v. Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994)). Beginning in 1980, as a cost-cutting measure, Congress "enacted a series of amendments designed to make Medicare a 'secondary' payer with respect to such plans." *Id.* These amendments, known as the Medicare Secondary Payer (MSP) provisions, state that, if an item or service covered by Medicare is also covered by a private health plan, the private plan is "primary" and Medicare is "secondary." Thus, when overlapping private and Medicare coverage exists, Medicare pays only if and to the extent it has a higher limit of coverage than the private plan. App. 2a. As one court put it, the secondary payer program "is intended to keep the government from paying a medical bill where it is clear an insurance company will pay instead." *Evanston Hosp. v. Hauck*, 1 F.3d 540, 544 (7th Cir. 1993); *accord Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir 1995).

Health care providers who supply a medical item or service to Medicare beneficiaries must decide in the first instance whether to submit a claim for payment to the Medicare system, to a private plan, or to the patient. To prevent improper billings, claim forms submitted to Medicare must indicate the existence of private coverage so CMS can independently assess its responsibility to pay. Medicare beneficiaries are similarly obligated to disclose any private coverage directly to the Medicare system. 42 U.S.C. § 1395y(b)(5)(D).

When a bill is submitted for payment, CMS is supposed to determine whether a private plan provides primary coverage. 42 U.S.C. § 1395y(b)(5). CMS, therefore, maintains a database of information about private health coverage, which is designed to link Medicare beneficiaries with private health plans. If the existence or extent of private coverage is in doubt, CMS can

request the necessary information from a variety of sources, including employers, who are statutorily required to provide it. 42 U.S.C. § 1395y(b)(5)(C).

If CMS nevertheless receives and pays a bill when private coverage applies, the Medicare system has several options to recover the money. All Medicare payments are conditional, so a doctor, hospital, or other provider who is paid by Medicare when private coverage applies must repay the funds. 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411.24. If Medicare pays for an item or service and the beneficiary also receives payment from another source, the beneficiary is similarly required to reimburse Medicare. 42 U.S.C. §§ 1395gg(a)–(b), 42 U.S.C. §§ 1395y(b)(1)(F). Medicare is also subrogated to the rights of "any individual, provider, supplier, physician, private insurer, state agency, attorney or other entity entitled to payment by a third party payer." 42 C.F.R. § 411.26; *see* 42 U.S.C. § 1395y(b)(2)(B)(iii)–(iv). Medicare may thus exercise any rights the patient or provider has to obtain payment under the beneficiary's private plan.

Finally, and most pertinent here, Medicare has a direct right of action to recover from entities that were "required or responsible" under the private plan to pay for the medical items or services in the first instance. 42 U.S.C. § 1395y(b)(2)(B)(ii). In relevant part, the statute provides that the government may recoup payment for a medical bill from:

> Any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.

Id.

Until recently, CMS read the direct action provision to allow recovery from employers when the employers were self-insured – that is, when employers had obligated themselves to pay providers for their employees' health care – but not when they merely had sponsored or funded third-party health insurance for their employees. In 1995, in fact, the agency published instructions to its fiscal intermediaries directing them to pursue reimbursement claims from insurance companies or HMO's and not from employers unless they were self-insured. Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, *Transmittal No. AB-95-9* (Aug. 1995). Sometime in the late 1990's, however, CMS reversed course and began demanding that even those employers that undertook no financial responsibility for their employees' medical bills pay Medicare for expenses it incurred under the secondary payer program. App. 11a, 46a-48a. It is this new recoupment practice that is at issue here.

B. The Instant Litigation

1. Petitioner Telecare Corp. is a family and employee owned business in California. It works with local, county, state, and other behavioral health organizations to provide services to adults who suffer from serious mental illness. Telecare makes available to its employees a prepaid health care plan from Kaiser Permanente Health Plan, an HMO. Under the terms of the plan, Telecare pays a premium to Kaiser, but Telecare "is not itself contractually obligated to pay health care providers for the[] medical services" covered by the plan. App. 3a. Some of Telecare's employees and their dependents are covered by Medicare, as well as the HMO plan.

In the late 1990's, the dependent of a Telecare employee incurred $1470.96 in medical expenses, for which Medicare initially paid. CMS later determined that the individual had private health coverage with Kaiser, and assumed that the Kaiser plan covered the items or services the dependent

received. Yet CMS never sought reimbursement from Kaiser (the entity contractually obligated to pay for covered expenses under the HMO plan). Instead, CMS demanded in a series of letters relying on the MSP direct action statute that Telecare compensate it for its payments.

2. After trying in vain to persuade the collection agency working on behalf of CMS that employers that fund third-party insurance coverage are not subject to the direct action statute, Telecare paid the sum demanded under protest. At roughly the same time, Telecare filed a class action complaint in United States District Court for the Northern District of California.[1] The named defendants (here, the Respondents) administer the Medicare Secondary Payer program. Telecare alleges that employers that provide third-party health insurance for employees are not "required or responsible" to pay the employees' medical bills and thus are not obligated to reimburse Medicare when it erroneously pays these bills. Grounding jurisdiction in the Little Tucker Act, 28 U.S.C. § 1346(a)(2), Telecare seeks to recover funds it paid under protest to CMS, as well as funds CMS has unlawfully obtained from other employers similarly situated.[2]

Respondents moved to dismiss, arguing that Telecare's complaint failed to state a claim for relief. The district court granted Respondents' motion without allowing any discovery

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[1] After Telecare filed its complaint, it received yet another letter from Medicare's collection agencies, this one demanding payment for medical services or items provided to another employee. This demand remains unpaid and unresolved.

[2] Telecare's complaint also requested certain declaratory or injunctive relief. The Federal Circuit dismissed these requests on the ground that "a final decision in the Little Tucker Act case by either this Court or the Supreme Court will finally resolve the issue as a practical matter and make repeated suits" – the thing Telecare sought to guard against through declaratory and injunctive relief – "unnecessary." App. 8a. Telecare takes the Federal Circuit at its word and does not seek declaratory or injunctive relief here.

or ruling on Telecare's pending motion for class certification. In a terse opinion, the district court reasoned that employers that fund third-party health insurance are "responsible" to pay their employees' medical bills because a different section of the Social Security Act requires employers, on pain of federal tax liability, to ensure that insurance plans they make available from third parties satisfy certain antidiscrimination rules. App. 29a-30a.

3. The Federal Circuit affirmed, but it did not even try to defend the district court's analysis. Instead, the Federal Circuit stated that although the term "responsible" often means "legally obligated" – a definition that "supports Telecare's position" – the term does not have that meaning in the MSP statute. App. 16a. Rather, according to the Federal Circuit, employers like Telecare are "responsible" to pay their employees' medical bills because "responsible" can also be defined as "involving a degree of accountability." *Id.* (quoting Webster's Third New International Dictionary of the English Language 1935 (3rd ed. 1961)). The Federal Circuit asserted that (but never explained how) this definition of "responsible" "easily encompasses employers who sponsor or contribute to a group health plan." *Id.*

The Federal Circuit also rejected Telecare's argument that rendering employers like it liable for their employees' bills would contravene the structure and purpose of the secondary payer system. Telecare pointed out that Congress and courts had always taken care to assure that only entities that had contracted to undertake liability to pay medical bills would ultimately be required to pay those bills, and that the Respondents' proposed construction of the MSP statute would leave employers like Telecare on the hook for medical expenses they never had agreed to cover. The Federal Circuit responded that "Telecare's concern . . . can be remedied if Telecare enters into agreements with insurance providers that allow for recourse [against the insurance providers] for the

same period as the government has recourse against Telecare as an employer." App. 20a. In any event, the Federal Circuit stated that "it is up to Congress, and not this Court, to decide whether the statute is fair to employers . . . ." *Id.* Notwithstanding the Federal Circuit's earlier acknowledgement that the dictionary's leading definition of "responsible" – unlike the one it had chosen to follow – "supports Telecare's position," App. 16a, the court asserted that "the plain language of the statute" foreclosed Telecare's argument. App. 19a.

REASONS FOR GRANTING THE WRIT

The Federal Circuit has fundamentally altered the basic meaning and operation of the Medicare Secondary Payer program. Until the decision below, every court to consider the issue had understood the program as allowing the government to recoup Medicare expenses from only private entities that were contractually obligated to pay for the medical costs at issue or indemnified by an entity that was. Not anymore. The Federal Circuit has now granted the government the ability under 42 U.S.C. § 1395y(b)(2)(B)(iii) to recover Medicare expenses from entities that have *no* financial responsibility for the medical bills at issue or recourse to an entity that is. In other words, the Federal Circuit has transformed a statute allowing the government to seek financial "reimbursement" into a statute allowing it to create and impose a new kind of financial liability that does not exist as a matter of private contact.

This Court should review this new conception of the Medicare Secondary Payer program without delay. After instructing collection agents for years that employers that arrange for their employees to obtain health insurance from third party insurance carriers are not "responsible" under § 1395y(b)(2)(B)(iii) for their employees' healthcare bills, the government has begun vigorously propounding the opposite position. And now that the Federal Circuit has condoned

Medicare's new practice, innumerable employers (particularly small businesses) stand to incur substantial new financial burdens. Even worse, they will find it very difficult to challenge the government's new practice in litigation, creating the very real possibility that the Federal Circuit's decision will become the final word on the matter unless promptly reviewed.

A. The Federal Circuit's Decision Fundamentally and Improperly Transforms the Medicare Secondary Payer Program.

When Medicare pays for a medical item or service for which private coverage applies, the Medicare Secondary Payer program allows the government to recover money it paid from an entity that was "required or responsible" to pay for those services under the private plan. 42 U.S.C. § 1395y(b)(2)(B)(ii). The program's direct action statute, in relevant part, provides that the government may recoup payment for a medical bill from:

> Any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.

Id. Although Congress added and then expanded the statute's first parenthetical over the years, it never has altered the language limiting the statute's reach to entities "required or responsible" to pay for the medical item or service at issue "under a primary plan." *Id.*

Accordingly, since its inception in 1980, the Medicare Secondary Payer program has been universally understood to regulate the order in which entities already obligated as a matter of private contract must cover health care expenses, not

to create a new obligation for entities as a matter of pure statutory law to cover health care expenses. That is, the secondary payer program makes private insurers primarily responsible, and Medicare secondarily responsible, for health care services that both entities cover. But whenever confronted with cases involving the secondary payer program, courts have taken it as a foundational tenet that "the MSP statute establishes a program of *reimbursement*," not liability. *Mason v. American Tobacco Co.*, 346 F.3d 36, 42 (2d Cir. 2003), *cert. denied*, 541 U.S. 1057 (2004) (emphasis in original).[3] The term "reimbursement" presupposes that the entity making the payment to the government had an obligation to make it in the first instance.

It is not surprising, therefore, that courts prior to the Federal Circuit here uniformly have agreed that a private party is not "required or responsible" to pay for a person's medical services unless it is obligated to do so under a "preexisting contractual obligation." *Id.*; *see also United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 875 (11th Cir. 2003) ("Medicare is empowered to recoup from *the rightful primary payer* . . . if Medicare pays for a service that was, or should have been, covered by the primary insurer.") (emphasis added), *cert. denied*, 124 S. Ct. 2907 (2004); *Waters v. Farmers Texas County Mut. Ins. Co.*, 9 F.3d 397, 401 (5th Cir. 1993) ("[T]he government stands exactly in [the beneficiary's] shoes when recovering from the available insurance funds."); *In re Dow Corning Corp.*, 250 B.R. 298, 345 (E.D. Mich. 2000) ("[F]or the Government to establish that it is entitled to reimbursement under the [MSP statute], it must step into the shoes of the insured and enforce her contractual rights."); *Manning v. Utilities Mutual Ins. Co.*, 2004 U.S. Dist. LEXIS 1674, at *20

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[3] The government itself consistently has characterized the MSP program as one that allows it to seek "reimbursement for expenses." *United States v. Michael*, 2001 WL 845362, at *5 (6th Cir. 2001) (quoting MSP program information guide).

(S.D.N.Y. Feb. 9, 2004) (MSP statute does not apply to "an employer that has contracted with an insurance carrier to provide . . . coverage to its employees").

In the one situation prior to the present controversy in which the government invoked the MSP statute to demand payment for medical services from entities that were not contractually obligated to cover them, the D.C. Circuit sharply rebuked the government's position. In the late 1980's and early 1990's, CMS (then called the Health Care Financing Authority) sought on several occasions to recover from entities that administered self-insured employer plans. Under these self-insured plans, employers who lacked the expertise to administer their plans often engaged the services of outside professionals to receive and review billings from providers, authorize or decline coverage, and write checks to providers. These third-party administrators (TPA's) were not themselves, however, obligated to pay for medical items or services. The self-insured employers bore that obligation.

The D.C. Circuit, agreeing with all of the district courts previously to address the issue, held that the MSP statute could not bear the government's broad interpretation of being "responsible" to pay for a medical service. *Health Ins. Ass'n v. Shalala*, 23 F.3d 412, 415-17 (D.C. Cir. 1994); *accord Provident Life & Acc. Ins. Co. v. United States*, 740 F. Supp. 492, 504 (E.D. Tenn. 1990); *United States v. Blue Cross & Blue Shield*, 726 F. Supp. 1517, 1521-22 (E.D. Mich. 1989). The statute, the D.C. Circuit explained, simply does not apply to those "that assume no financial responsibility for paying the plan's benefits." *Health Ins. Ass'n*, 23 F.3d at 416. It called the government's argument to the contrary "a complete jumble." *Id.* at 417.

Congress responded to this decision by amending the MSP statute to allow the government to sue TPA's, *but only when the TPA's themselves are indemnified by the entity*

contractually responsible under the health care plan at issue for doing so. See 42 U.S.C. § 1395y(b)(2)(B)(iii). Congress, therefore, implicitly approved the D.C. Circuit's refusal to extend the MSP statute in a manner that might force an entity lacking any contractual financial responsibility for medical services to pay for those services. *See In re Dow Corning Corp.*, 250 B.R. at 336 n.21. The MSP statute remained, as it was before, merely a tool for facilitating reimbursement from the "rightful primary payer." *Baxter*, 345 F.3d at 875.[4]

The decision below conflicts with this previously uniform understanding. The Federal Circuit held, for the first time, that the government can force an entity to pay it for Medicare expenses even though the entity neither has contractually agreed to cover an individual's medical costs, nor is contractually indemnified by an entity that has. The Federal Circuit ruled that such an entity is "responsible" for such medical expenses when they sponsor a third-party health plan because such sponsorship "involve[s] a degree of accountability" for the expenses. App. 16a (quotation omitted). The Federal Circuit never explains what having a "degree of accountability" means or how even that standard is satisfied here, but it is clear that the standard most assuredly does *not* require the entity the government is billing to be the rightful primary payer.

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[4] Following Congress's response to the *HIAA* litigation, the government itself reaffirmed that "[t]he Medicare Secondary Payer (MSP) program is essentially the same concept known in the private insurance industry as coordination of benefits." 63 Fed. Reg. 26,810 (1998). The doctrine of "coordination of benefits" comes into play when a person's two private healthcare plans both cover a certain item or service. The doctrine determines which plan provides primary coverage; it never transfers financial responsibility onto a third party. *See, e.g.*, National Association of Insurance Commissioners, Group Coordination of Benefits Model Regulations § 5 (2004); *William Brown Co. v. General Am. Life Ins. Co.*, 450 N.W.2d 867, 873 (Iowa 1990).

The Federal Circuit's decision, simply put, is inconsistent with the very concept of a secondary payer program. Instead of allowing the government merely to force a rightful primary payer to cover healthcare costs it should have covered in the first place, the Federal Circuit's decision allows the government to foist the responsibility for covering costs onto entities that never agreed to cover them. This stretches beyond its breaking point the statutory requirement that entities the government pursues under the MSP statute be "responsible . . . under a primary plan" for paying for the medical services at issue. 42 U.S.C. § 1395y(b)(2)(B)(iii).

It is no answer to say, as the Federal Circuit did, that allowing the government to obtain payment from entities like Telecare is necessary to give meaning to the MSP statute's parenthetical suggestion that it applies to, among other entities, "an employer that sponsors or contributes to a group health plan." App. 12a-13a (quoting 42 U.S.C. § 1395y(b)(2)(B)(iii)). The parenthetical sets forth various categories of entities that may be subject to the government's recoupment power: "an insurer or self-insurer, [] a third-party administrator, [] an employer that sponsors or contributes to a group health plan, or large group health plan." *Id.* Although this list might appear at first glance to cover all self-insured employers under the term "self-insurer," leaving the "employer" category to apply to third-party insurers like Telecare, the term "self-insurer," like any other "member of a sentence," must be interpreted in light of "the provisions of the whole law, and . . . its object and policy." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 94-95 (1993).

When one reviews the remainder of the MSP statute, one sees that another section of the MSP statute limits the definition of "self-insurer" to entities engaged in a "business, trade, or profession." 42 U.S.C. § 1395y(b)(2)(A). Thus, the parenthetical reference to "self-insurers" does not otherwise cover self-insured employers that are, for example, nonprofit or

charitable organizations. The "employer" category the Federal Circuit relied on consequently can be interpreted, in conjunction with the terms in the remainder of the MSP statute and consistent with the notion of a secondary payer system, to allow Medicare to seek reimbursement from such self-insuring nonprofit or charitable or employers.

The Federal Circuit, however, focused solely on the fact that the parenthetical reference to "employer[s] that sponsor[] or contribute[] to a group health plan," read in isolation, could also be read more broadly to suggest that any such employer, regardless of whether it self-insures, is subject to the government's recoupment power. This construction, however, ignores the contextual meaning of the "employer" phrase. It also required the Federal Circuit to ascribe the word "responsible" an unnaturally expansive meaning – a reading that, even still, does not seem to cover employers that have no financial responsibility for their employees' medical expenses. *See supra* at 11.

Worse yet, the Federal Circuit's statutory construction requires reading the words "under a primary plan" – which specifies how an entity must be responsible for a medical expense at issue – entirely out of the statute. Under the government's own regulations, "plan" means an "arrangement, oral or written . . . [to] assume legal liability." 42 C.F.R. § 411.21. A primary plan, in other words, is a vo ntary, private agreement to cover certain costs. Yet employers like Telecare have not made any arrangement of any kind to bear any liability for their employees' medical bills. They have made just the opposite kind of arrangement – an arrangement under which another entity bears that responsibility.

Forced to choose between reading one parenthetical phrase narrowly and reading two operative phrases out of the statute, it should have been clear that the former, more modest, approach was preferable. The Federal Circuit unjustifiably

chose the more radical approach, flouting the previously well-settled understanding of the secondary payer program and transforming the direct action statute from a reimbursement provision into a liability provision.

B. The Federal Circuit's Decision Stands Seriously To Harm Innumerable Employers That Were Not Previously Liable For Their Employees' Healthcare Expenses.

Prior to the Federal Circuit decision here, "the [MSP] provision" – with one irrelevant exception – "ha[d] apparently never successfully been used to pursue a non-insurance entity." *Mason*, 346 F.3d at 42 (quoting *United States v. Philip Morris, Inc.*, 156 F. Supp. 2d 1, 5 (D.D.C. 2001)).[5] Yet the Federal Circuit's decision not only allows the government, for the first time, to collect money from a non-insurance entity, but it acknowledges that "it is possible that [a non-insurance entity] will be liable under the MSP statute even when it cannot seek reimbursement from [the third-party insurer]." App. 18a-19a. The significance of this change to the Medicare Secondary Payer program can hardly be understated.

This case provides a perfect example. Telecare's contract with its third-party insurer, Kaiser Foundation Health Plan, provides that Telecare may seek reimbursement for a healthcare bill that Telecare pays because Kaiser unjustifiably failed to cover it. But Telecare has only one year from the medical service at issue to do so. The MSP statute, in contrast,

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[5] That exception is the government's ability to use the MSP statute to recoup Medicare expenses from certain tortfeasors, such as tobacco companies. *See* 42 U.S.C. § 1395y(b)(2)(A). But this isolated exception is actually perfectly consistent with pursuing insurance entities. When a tortfeasor is required to pay damages for healthcare expenses that Medicare initially covered, the tortfeasor becomes legally responsible for such expenses. The Social Security Act actually defines this situation as a form of "self-insur[ance]." *Id.*

allows the government to commence actions under the direct action provision any time within *three years* of a medical treatment. 42 U.S.C. § 1395y(b)(2)(B)(vi). This means that whenever the government brings a direct action against an employer like Telecare more than one year from the delivery of the medical item or service (as it almost always does), the employer – and not the insurer that undertook financial responsibility for coverage – will end up holding the bag.

Faced with this incongruity, the Federal Circuit suggested that employers could protect themselves by "enter[ing] into agreements with insurance providers that allow recourse for the same period as the government has recourse against [the employers]." App. 20a. But this suggestion has no support and is painfully naïve. Insurance companies impose short deadlines for submitting claims so they can effectively investigate and verify coverage. Even the U.S. military health insurance plan provides that claims must be filed with private insurers within one year. *See* 32 C.F.R. § 199.4(a)(7). While it might be possible for a handful of huge employers to extract more favorable terms from insurance companies, it will be nearly impossible for small, or even ordinary, businesses to do so.

Even if garden-variety employers had the power to force insurance companies equalize the applicable limitations periods, they would still face the very real prospect of being saddled with unjustified liability. Medical privacy rules make it extremely burdensome and expensive for non-insuring employers to determine what type of care their employees or their dependents received. So when faced with governmental demands for payment, typical employers often do not have available resources to determine whether coverage even applies. Furthermore, employers typically establish third-party insurance arrangements for their employees in part precisely because they lack the expertise or practical ability to determine insurance-coverage issues. The Federal Circuit's decision

threatens to make such a lack of proficiency a very tempting target for the government and a very costly trait for the employers. CMS places the onus on employers to show that the plan does not cover the medical expenses in question, so employers may often provide reimbursement even when the private coverage does not apply.

Faced with substantially increased costs attendant to sponsoring or contributing to third-party insurance for their employees, small businesses and other employers will likely simply cease offering such insurance or significantly reduce its scope. This disincentive the Federal Circuit has created is, of course, quite ironic. The core purpose of the Medicare Secondary Payer program is to save Medicare money. *See, e.g., New York Life Ins. Co. v. United States*, 190 F.3d 1372, 1373 (Fed. Cir. 1999); *Health Ins. Ass'n*, 23 F.3d at 414. But if – as seems probable – private entities eliminate or limit private insurance for their employees, Medicare costs will *increase* because Medicare will become the primary insurance source for more and more Americans.

There is no reason to go down this road. In every instance in which the government claims a right to pursue claims against an employer like Telecare, CMS has not one but two other sources for reimbursement: the provider who sent Medicare the bill improperly and, under the direct action statute, the insurance carrier who should have received it. The Federal Circuit's decision needlessly threatens a large class of American businesses.

C. This Court Should Promptly Rectify The Federal Circuit's Misconception Of The Secondary Payer Program.

This Court should not wait for any further developments before reviewing the position that the Federal Circuit has adopted with respect to employers that arrange for their

employees to obtain insurance from third parties. Even before the Federal Circuit ruling, CMS was mailing letters across the country to employers such as Telecare demanding payment for their employees' medical expenses. *See* App. 46a-49a (standard letter used prior to this litigation).[6] Now that a federal appellate court has condoned this practice, the government is sure to increase its use. CMS stands (illegitimately) to collect millions of dollars per year from thousands of employers with insurance arrangements like Telecare's. *See* United States Government Accountability Office, *Medicare Secondary Payer: Improvements Needed To Enhance Debt Recovery Process*. GAO-04-783, at 10-11 (2004) <http://www.gao.gov/new.items/d04783.pdf> (estimating costs involved in MSP program). And as the new Medicare prescription drug benefit program becomes implemented, these numbers are sure to grow.

Equally important, the government's demand letters are unlikely to lead to any new lawsuits on this particular subject. Although the financial stakes here are large in the aggregate, there is usually only a few thousand dollars at stake in the typical coverage dispute. (Telecare's medical bill at issue here amounts to $1470.96.) This reality, coupled with the fact that CMS's letters threaten to seek double damages and impose tax penalties unless payment is made, App. 48a-49a, make challenging the government's position in any particular dispute seem hardly worth it. (That is why Telecare filed a class action here.)

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[6] The government's standard letter predating this litigation suggested that three federal courts had held that it could recover Medicare expenses from employers that provide insurance "from an insurance company." App. 46a-48a. The truth is that none of these cases so held; each involved third party administrators working for *self-insured* employers. Indeed, despite the representations the government's demand letter made to employers, the government never has contended in this litigation that any of the three cases supports its position.

The government is unlikely to initiate any new lawsuits either. If an employer refuses to comply with a demand letter, the government need not actually file a lawsuit in order to use the direct action statute to obtain the money it seeks. Instead, relying merely on its statutory ability to do so, it can (and commonly does) invoke the Treasury Offset Program, which is part of the Debt Collection Improvement Act, 31 U.S.C. § 3711 *et seq.*, simply to take the money out of the employer's tax refund. *See* 31 U.S.C. § 3720A.[7]

Even if a few employers in the future are moved to sue CMS to get their money back (money that either the federal government took from their tax refunds or that the employers paid under protest), those lawsuits would have to be brought under the Little Tucker Act or (if an unusually large amount is at stake) the Tucker Act. Either way, appellate jurisdiction would rest, just like this case, in the Federal Circuit. *See* 28 U.S.C. § 1295(a). Therefore, any further percolation that occurs with respect to the particular question presented here would serve no useful purpose; it would serve only to further entrench the government's unlawful practice.

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[7] The Debt Collection Improvement Act requires that all debts over 180 days delinquent to be transferred to the Department of the Treasury. The Department coordinates collection efforts through the use of demand letters, credit reporting, collection agents, tax offsets, and other means. *See* Financial Management Service, Debt Management Services, Debt Services Division, *Cross-Servicing Implementation Guide* (May 2004) <http://www.fms.treas.gov/debt/Crosserv/dmxguide.pdf>. During an earlier dispute between CMS and Telecare, for example, CMS confiscated a tax refund the government owed to Telecare.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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United States Court of Appeals
for the Federal Circuit

04-1389

TELECARE CORP.,

Plaintiff-Appellant,

v.

MIKE LEAVITT, Secretary of Health and Human Services, DEPARTMENT OF HEALTH AND HUMAN SERVICES, and CENTER FOR MEDICARE AND MEDICAID SERVICES,

Defendants-Appellees.

DECIDED: May 25, 2005

Before CLEVENGER, RADER, and DYK, *Circuit Judges*.

DYK, *Circuit Judge*.

This case involves a dispute between Telecare Corp. ("Telecare") and the government as to Telecare's liability under the Medicare Secondary Payer statute, Social Security Act § 1862, codified at 42 U.S.C. § 1395y. The United States District Court for the Northern District of California held that Telecare was liable as a secondary payer. We affirm.

BACKGROUND

I

The defendants in this case administer the Medicare program. Medicare provides health insurance to the

elderly, the disabled, and other eligible beneficiaries. Medicare was enacted in 1965 as Title 18 of the Social Security Act, commonly known as the Medicare Act. *See* Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 286 (1965).

Beginning in 1980, Congress provided that where beneficiaries are covered for medical expenses by both a group health plan and Medicare, Medicare would be a "secondary payer" of those medical expenses. This provision is known as the Medicare Secondary Payer ("MSP") statute and is found at section 1862 of the Social Security Act, codified as 42 U.S.C. § 1395y. "When the MSP statute applies, a private group health plan must pay for an expense first. Thus, it is the 'primary payer.' Medicare pays for any remaining amount of the expense not satisfied by the group health plan. Consequently, it is the 'secondary payer.'" *N.Y. Life Ins. Co. v. United States*, 190 F.3d 1372, 1374 (Fed. Cir. 1999).

Although a private group health plan is obligated to make payment when primarily liable, and Medicare is to avoid payment in such circumstances, Medicare nonetheless sometimes makes payments in error. *See United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 901 & n.30 (11th Cir. 2003). The government has the right to reimbursement in such circumstances, and that reimbursement right is not limited to the beneficiary, the health care provider, or the group health plan. Under the statute, as amended in 2003, the government may recoup the payment from

> *any or all entities that are or were required or responsible* (directly, as an insurer or self-insurer, as a third-party administrator, *as an employer that sponsors or contributes to a group health*

> *plan*, or large group health plan, or otherwise) *to make payment* with respect to the same item or service (or any portion thereof) under a primary plan. . . .

Social Security Act § 1862(b)(2)(B)(iii), codified at 42 U.S.C.A. § 1395y(b)(2)(B)(iii) (Supp. 2004) (emphasis added).

The issue in this appeal is whether the statute authorizes recovery against an employer that "sponsors or contributes to" a group health plan.

II

Telecare is a company that provides services to those suffering from mental illness. The issue concerns Telecare's liability for Medicare payments made to Telecare's employees (and their dependents). Telecare makes available to its employees a prepaid health care plan from Kaiser Foundation Health Plan and pays a premium to Kaiser, thereby sponsoring and contributing to the group health plan. Under the arrangement between Kaiser and Telecare, Kaiser is obligated to provide a defined list of health care items and services for Telecare employees and their dependents. Telecare is not itself contractually obligated to pay health care providers for these medical services.

Some of Telecare's employees and their dependents are also covered by Medicare. One such individual incurred medical expenses, for which Medicare initially paid. Invoking the MSP statute, Medicare then demanded that Telecare reimburse it, allegedly without seeking payment from the group health plan (Kaiser). Telecare eventually paid Medicare the sum of $1470.96 under protest. Telecare then filed this action in the United States District Court

for the Northern District of California, seeking recovery of the amount paid to Medicare under the Little Tucker Act, 28 U.S.C. § 1346(a)(2), and declaratory and injunctive relief against further reimbursement demands under the Administrative Procedure Act ("APA"), 5 U.S.C. § 701 *et seq.* Telecare also sought class certification with respect to the APA claim.

The district court dismissed the complaint. The district court held that there was jurisdiction over Telecare's claim for $1470.96 under the Little Tucker Act but dismissed the suit for failure to state a claim, because the MSP statute, as amended in 2003, gave Medicare the right to seek reimbursement from Telecare. *Telecare Corp. v. Thompson*, No. 03-CV-3797, slip op. at 2-3, 6-7 (N.D. Cal. 2004). The district court concluded that "[a]n employer that sponsors or contributes to a group health plan . . . falls squarely into the language of the statute." *Id.* at 6. The district court dismissed the APA claim for lack of jurisdiction because there was no APA waiver of sovereign immunity where an adequate remedy existed under the Tucker Act or Little Tucker Act to recover the amounts illegally extracted by the government.[1] *Id.* at 2-3. The district court did not rule on Telecare's motion for class certification. Telecare appeals.[2]

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[1] The district court also held that the APA claim was not ripe for adjudication. *Id.* at 3-5.

[2] While Telecare moved for class certification, no class was certified. Accordingly, only Telecare is before this court on appeal.

DISCUSSION

I

We must first consider whether the district court had jurisdiction over the claim for $1470.96 under the Little Tucker Act. Although the government concedes jurisdiction under the Little Tucker Act, every "appellate federal court must satisfy itself not only of its own jurisdiction, but also of that of the lower courts in a cause under review." *Mitchell v. Maurer*, 293 U.S. 237, 244 (1934).

"The Tucker Act provides jurisdiction to recover an illegal exaction by government officials when the exaction is based on an asserted statutory power." *Aerolineas Argentinas v. United States*, 77 F.3d 1564, 1573 (Fed. Cir. 1996). Because the amount claimed is less than $10,000, the Little Tucker Act on its face grants the district court jurisdiction to determine whether Telecare was entitled to the return of $1470.96. *See* 28 U.S.C. § 1346(a)(2) (2000).

However, as we recently held in *Wilson v. United States*, 405 F.3d 1002 (Fed. Cir. 2005), Tucker Act jurisdiction is limited in Medicare cases by sections 205 and 1872 of the Social Security Act. Specifically, § 205(h), as modified by § 1872, provides:

> The findings and decisions of the [Secretary of Health and Human Services] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. *No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code [the Little*

> *Tucker Act] to recover on any claim arising under [the Medicare Act].*

Social Security Act § 205(h), codified at 42 U.S.C. § 405(h) (2000).

Section 205(h) thus bars Little Tucker Act jurisdiction and federal question jurisdiction for a claim "arising under" the Medicare Act. We have read section 205(h) to bar Tucker Act jurisdiction as well for "arising under" claims brought under the Tucker Act itself. *Wilson*, slip op. at 11. The question is the meaning of the "arising under" language of § 205(h). In *Wilson*, we held that a claim "arises under" the Medicare Act if the claim is subject to the specialized review process of sections 205(g) and 1869 of the Social Security Act (codified at 42 U.S.C. §§ 405(g) and 1395ff). *Wilson*, slip op. at 11 n.9. Section 1869(a)(1) provides, *inter alia*, for an initial determination by the Secretary of "whether an individual is entitled to benefits." Section 1869(b)(1)(A) provides:

> [A]ny individual dissatisfied with any initial determination under subsection (a)(1) shall be entitled to reconsideration of the determination, and . . . a hearing thereon by the Secretary . . . and . . . to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Social Security Act § 1869(b)(1)(A), codified at 42 U.S.C.A. § 1395ff(b)(1)(A) (Supp. 2004).

In *Wilson* we held that the plaintiff was asserting a claim of entitlement to benefits and thus the claim "arose under" the Medicare Act. In that case, Medicare determined that it overpaid benefits to Wilson, and Medicare sought to recover that overpayment from him. Wilson paid

Medicare but then sued to get the money back. We held that such a suit was "essentially a claim contesting the agency's initial determination that it overpaid benefits to [] Wilson, and [was] thus a claim for benefits." *Wilson*, slip op. at 17. Because the specialized administrative and judicial review process of sections 1869 and 205(g) applied to claims for benefits, Tucker Act jurisdiction was barred by section 205(h). The same would, of course, apply to a suit under the Little Tucker Act, which is expressly barred when a suit "arises under" the Medicare Act.

However, we also noted in *Wilson* that "[w]e do not suggest that the application of [section 205(h)] precludes judicial review through other avenues in cases where the specialized administrative and judicial review processes provided in the statute are not available." *Id.*, slip op. at 11, n.9. In this case, Medicare did not assert that it overpaid benefits to Telecare, but rather to Telecare's employee. Telecare is not asserting, and cannot assert, any claim of entitlement to Medicare benefits, or any other claim under section 1869(a)(1). The specialized review process is thus not available.[3] Because Telecare cannot invoke the specialized administrative and judicial review process of sections 1869 and 205(g), section 205(h) does not apply. Indeed, the government here concedes that Telecare's money claim is "properly presented under the Little Tucker Act." (Br. of Appellee at 31.) Therefore, the district court properly had jurisdiction under the Little Tucker Act to adjudicate Telecare's claim for $1470.96.

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[3] Telecare could have challenged the asserted indebtedness through administrative procedures under the Debt Collection Improvement Act of 1996, 31 U.S.C. § 3711, but not under the Medicare administrative process.

II

In addition to the Little Tucker Act, Telecare also seeks declaratory and injunctive relief to bar further demands for payment under the APA. The APA contains a waiver of sovereign immunity for suits to "set aside agency action . . . found to be . . . in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706 (2000). But the APA waives sovereign immunity only if there is "no other adequate remedy." 5 U.S.C. § 704 (2000).

The availability of an action for money damages under the Tucker Act or Little Tucker Act is presumptively an "adequate remedy" for § 704 purposes. *Christopher Village, L.P. v. United States*, 360 F.3d 1319, 1327-29 (Fed. Cir. 2004); *Consol. Edison Co. of N.Y. v. United States*, 247 F.3d 1378, 1382-84 (Fed. Cir. 2001); *see Martinez v. United States*, 333 F.3d 1295, 1320 (Fed. Cir. 2003) (en banc). Because Telecare can bring an action under the Tucker Act or Little Tucker Act to redress the allegedly improper exaction, there is no waiver of sovereign immunity under the APA. Telecare contends that the remedy is not adequate because it could recover the amounts illegally demanded by Medicare only by repeatedly bringing suit, but a final decision in a Little Tucker Act case either by this court or the Supreme Court will finally resolve the issue and as a practical matter make repeated suits unnecessary. *See Consol. Edison*, 247 F.3d at 1384. The district court correctly dismissed Telecare's APA claim for declaratory and injunctive relief for lack of jurisdiction.[4]

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[4] Telecare also asserted a claim to the $1470.96 under the APA. Such a claim is also clearly barred as a suit under the Little Tucker Act is an adequate remedy.

III

We proceed to the merits of Telecare's Little Tucker Act claim. On the merits of Telecare's Little Tucker Act claim for $1470.96, this case requires us to interpret the MSP statute. Originally, Medicare "paid for services without regard to whether they were also covered by an employer group health plan." *N.Y. Life*, 190 F.3d at 1373. As noted earlier, the MSP statute was first enacted in 1980 to make Medicare secondarily liable to liability insurance plans and workmen's compensation plans. Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, sec. 953, § 1862, 94 Stat. 2599, 2647. Its provisions were extended to make Medicare secondarily liable to group health plans in 1981. Medicare and Medicaid Amendments of 1981, Pub. L. No. 97-35, sec. 2146(a), § 1862, 95 Stat. 357, 800-01. Medicare was not obligated to pay for certain medical services if payments had been made or would be made "promptly" by a group health plan.[5]

Section 1862(b)(2)(B) of the 1981 statute then provided, in pertinent part:

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[5] The 1981 statute provided:

> [P]ayment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service . . . to the extent that payment with respect to expenses for such item or service (i) has been made under any group health plan . . . or (ii) the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this title.

Social Security Act § 1862(b)(2)(A), codified at 42 U.S.C. § 1395y(b)(2)(A) (1976 & Supp. V 1981).

> Any payment under this title with respect to any item or service . . . shall be conditioned on reimbursement to the appropriate Trust Fund . . . when notice or other information is received that payment . . . has been made under a plan.

Thus Medicare was entitled to reimbursement by the beneficiary or the health care provider who had received "payment" from Medicare, but there appeared to be no provision for the Secretary to seek payment from the group health plan. *See* H.R. Rep. No. 98-432, at 1803 (1984).

In 1984, the statute was amended to authorize actions by the United States to recover payments from entities "responsible" for payment. Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, sec. 2344(c), § 1862(b)(3), 98 Stat. 494, 1095-96. The 1984 statute provided, in pertinent part:

> In order to recover payment made under this title for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan.

Social Security Act, § 1862(b)(3)(A), codified at 42 U.S.C. § 1395y(b)(3)(A) (1982 & Supp. II 1984). The language of the statute clearly allowed the United States to recover payments from the group health plan.

In the late 1980s, Medicare asserted that it could also seek recovery from third-party administrators ("TPAs") of group health plans as well as the entity that bore the ultimate financial burden of the plan. The litigation culminated in the District of Columbia Circuit's decision in

Health Insurance Association of America, Inc. v. Shalala, 23 F.3d 412, 417 (D.C. Cir. 1994) ("HIAA"), holding that the then-existing statute did not provide for recovery against TPAs.

Congress amended the statute in 1997 to allow Medicare to recover against TPAs and others "required or responsible . . . to make payment." Balanced Budget Act of 1997, Pub. L. No. 105-33, sec. 4633(a), § 1862, 111 Stat. 251, 487. The statute, in pertinent part, was amended to read:

> In order to recover payment made under this title for such an item or service, the United States may bring an action against any entity which is required or responsible *(directly, as a third-party administrator, or otherwise) to make payment* with respect to such item or service (or any portion thereof) under a primary plan.

Social Security Act § 1862(b)(2)(B)(ii), codified at 42 U.S.C. § 1395y(b)(2)(B)(ii) (2000) (prior to 2003 amendment) (1997 amendment emphasized). The legislative history makes clear that this amendment was in response to the *HIAA* decision. The House Report stated: "A 1994 appeals court decision held that [Medicare] could not recover from third party administrators of self-insured plans. . . . The provision would permit recovery from third party administrators of primary plans." H.R. Rep. No. 105-149, at 739 (1997).

Beginning in 2000, Medicare asserted that it could seek recovery from employers who sponsored or contributed to third-party health insurance for their employees, relying on the "or otherwise" language of the 1997 amendment. Telecare and other employers disputed this

interpretation, leading to the filing of the present suit in August 2003. While the suit was pending, in December 2003, Congress again amended the MSP statute. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, sec. 301(b)(3), § 1862(b)(2)(B), 117 Stat. 2066, 2222. The amendments were made effective retroactively to 1980.[6] *Id.* sec. 301(d)(2). The amended statute provides:

> (iii) Action by United States. In order to recover payment made under this title for an item or service, the United States may bring an action against any *or all entities that are or were* required or responsible (directly, *as an insurer or self-insurer*, as a third-party administrator, *as an employer that sponsors or contributes to a group health plan, or large group health plan*, or otherwise) to make payment with respect to *the same* item or service (or any portion thereof) under a primary plan. *The United States may*, in accordance with paragraph (3)(A) collect double damages against *any such* entity. *In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.*

Social Security Act § 1862(b)(2)(B)(iii), codified at 42 U.S.C.A. § 1395y(b)(2)(B)(iii) (Supp. 2004). The changes in language from the 2003 amendments are emphasized.

The parties discuss at some length the various regulations under the statute, the appropriate construction of

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[6] Telecare does not argue that the amendments cannot be retroactively applied.

those regulations, and the question of deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). We need not address those questions because we conclude that the statute's plain language compels a finding that all employers who sponsor or contribute to a group health plan are liable.

Telecare first argues that the term "employer" should be limited to self-insured employers. We see no basis for limiting the term "employer" in this way, and Congress specifically and separately provided for recovery from self-insurers in the same statutory provision.[7] Telecare concedes that it "makes available to its employees a prepaid health care plan from Kaiser [and] . . . pays a premium to Kaiser." (Br. of Appellant at 3.) Telecare is thus clearly "an employer that sponsors or contributes to a group health plan." It argues, however, that this does not create liability because it is not "required or responsible . . . to make payment . . . under a primary plan." In essence, Telecare argues that there is a conflict between the "employer" language inside the parenthetical and the "required or responsible" language outside the parenthetical, and it urges us to disregard the "employer" language within the parenthetical, following the Supreme Court's decision in *Chickasaw Nation v. United States*, 534 U.S. 84 (2001). However, *Chickasaw* does not support Telecare's proposed interpretation of the statute.

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[7] In urging that its proposed construction would not render the term "self-insurer" superfluous, Telecare argues that the term "self-insurer" in § 1862 encompasses only self-insured entities engaged in a business, trade or profession, and that inclusion of the term "employer" was necessary to cover self-insured governmental and charitable employers. This argument has no support in the language of the statute, and is without merit.

Chickasaw involved the interpretation of 25 U.S.C. § 2719, which provided: "The provisions of [the Internal Revenue Code of 1986] (including sections 1441, 3402(q), 6041, and 60501, and chapter 35 of such [Code]) concerning the reporting and withholding of taxes . . . shall apply to Indian gaming operations . . . in the same manner as such provisions apply to State gaming and wagering operations." The problem was that Chapter 35 was not a reporting or withholding provision, but rather imposed taxes. The petitioners in *Chickasaw*, Indian tribes who had gaming operations, argued that under section 2719 they were exempt from Chapter 35 taxes because the states were exempted. The Supreme Court rejected the argument for exemption. It found an irreconcilable conflict between the language inside and outside the parenthetical, and concluded that the language outside the parenthetical governed. The Court concluded that it could "find no other reasonable reading of the statute," except to reduce the reference to Chapter 35 in the parenthetical to "surplusage." 534 U.S. at 89. The Court noted that "the language outside the parenthetical is unambiguous." *Id.* It would not have been possible to regard the parenthetical in § 2719 as defining "reporting" or "withholding" to include the provisions of Chapter 35 because the two terms are used repeatedly and have well-established meanings in the Internal Revenue Code. *See, e.g.*, I.R.C. § 3402 (2000) (prescribing the withholding of income tax from wages); I.R.C. § 6053 (2000) (prescribing reporting requirements for tips). The Court concluded that "the more plausible role for the parenthetical to play in [25 U.S.C. § 2719] is that of providing an illustrative list of examples . . . , in context, common sense suggests that the cross-reference [to Chapter 35] is simply a drafting mistake, a failure to delete an inappropriate cross-reference in the

bill that Congress later enacted into law." *Chickasaw*, 534 U.S. at 90-91.

Telecare's reliance on *Chickasaw* is misplaced. As we now discuss, there is no irreconcilable inconsistency between the language inside and outside the parenthetical in the MSP statute. There is thus nothing in the MSP statute itself or the legislative history to indicate that Congress made a drafting mistake.

Telecare's attempt to find a conflict between the words inside and outside the parenthetical in § 1862 rests with the contention that "responsible" means "legal[ly] obligat[ed]." (Reply Br. of Appellant at 7.) We reject this reading for several reasons.

First, since Congress used the term "required" as well as "responsible", it seems unlikely that Congress intended to give "responsible" the same meaning as "required." Telecare cites *Neal v. Clark*, 95 U.S. 704, 708-09 (1877), for the canon that: "[T]he coupling of words together shows that they are to be understood in the same sense." That is true but irrelevant, for "same sense" does not mean "identical." *Neal* construed the word "fraud" in the bankruptcy statute in light of the adjoining word "embezzlement," and held that fraud required moral turpitude or intentional wrongdoing since those were required for embezzlement. *Id.* at 709. *Neal* did not give "fraud" and "embezzlement" identical meanings. Telecare's proposed interpretation, that "required" and "responsible" mean the same thing, instead violates the canon that courts should be "reluctant to treat statutory terms as surplusage in any setting." *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (internal quotations omitted).

Second, the Supreme Court has held that the plain meaning of a statute is to be ascertained using standard dictionaries in effect at the time of the statute's enactment. *Lamar v. United States*, 241 U.S. 103, 113 (1916). The dictionary offers various definitions of "responsible" including "liable or subject to legal review or in case of fault to penalties," and "involving a degree of accountability." *Webster's Third New International Dictionary of the English Language* 1935 (3d ed. 1961). Although the first definition supports Telecare's position that "responsible" means "legally obligated," the other definition supports a concept of indirect responsibility. The statute itself contemplates that some entities are "directly" liable, *i.e.* legally obligated, thus suggesting that the other covered entities are only indirectly responsible. By distinguishing between "directly" responsible entities and other entities the parenthetical indicates that an employer's responsibility may be either direct or indirect. Thus we think that the word "responsible" means "involving a degree of accountability," a definition that easily encompasses employers who sponsor or contribute to a group health plan.

Even if the ordinary meaning of "responsible" were limited to "legally obligated," the same result would obtain. Statutes frequently define words in a manner that diverges from ordinary meaning. And this can be done through a parenthetical as well as a specific definitional provision, as the Supreme Court's decision in *Pinellas Ice & Cold Storage Co. v. Commissioner*, 287 U.S. 462, 469-70 (1933) makes clear. In *Pinellas Ice*, the Supreme Court interpreted "reorganization" under section 203 of the Revenue Act of 1926. The relevant section stated: "[t]he term 'reorganization' means (A) a merger or consolidation (including the acquisition by one corporation of at least a

majority of the voting stock and at least a majority of the total number of shares of all other classes of stock of another corporation, or substantially all the properties of another corporation). . . ." Revenue Act of 1926, ch. 27, § 203(h)(1), 44 Stat. Pt. 2, 9, 14. The Fifth Circuit had held that, despite the language of the parenthetical, "merger or consolidation" should be limited to its ordinary meaning, which was "an acquisition of substantially all the property of another corporation." *Pinellas Ice & Cold Storage Co. v. Commissioner*, 57 F.2d 188, 190 (5th Cir. 1932). The Supreme Court rejected this interpretation, holding that:

> The words within the parenthesis may not be disregarded. They expand the meaning of "merger" or "consolidation" so as to include some things which partake of the nature of a merger or consolidation *but are beyond the ordinary and commonly accepted meaning of those words* – so as to embrace circumstances difficult to delimit but which in strictness cannot be designated as either merger or consolidation.

Pinellas Ice, 287 U.S. at 469-70 (emphasis added).

Telecare attempts to distinguish *Pinellas Ice* by arguing that where the parenthetical comes at the end of the statutory language, the parenthetical is defining; but because the parenthetical in § 1862 comes in the middle of the statutory language, it is not defining. We do not think that appellant has articulated a meaningful distinction between the two situations. *Pinellas Ice* holds that parentheticals may define terms beyond their "ordinary and commonly accepted meaning," *id.*, so long as the statute

itself permits such a definition.[8] Here, even if Telecare's view as to the ordinary meaning of "responsible" were to be accepted, the parenthetical defines the word to have a broader meaning in this particular statute.

IV

Telecare finally argues that imposing liability on it would be contrary to the policy and purpose of the MSP statute. Telecare notes that the MSP statute unquestionably allows Medicare to seek reimbursement from Kaiser, and argues that an additional remedy against Telecare is unnecessary. It also urges that allowing recovery against an employer is unfair. Telecare points out that under its contract with Kaiser, it has only one year to seek reimbursement from Kaiser, whereas the United States has three years to bring an action under the MSP statute. Social Security Act § 1862(b)(2)(B)(vi), codified at 42 U.S.C.A. § 1395y(b)(2)(B)(vi) (Supp. 2004). Therefore, it is

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[8] As noted above, in *Chickasaw*, the language of the statute did not permit such a construction. As the Supreme Court stated:

> The language of the statute is too strong to bend as the Tribes would wish – i.e., so that it gives the chapter 35 reference independent operative effect. For one thing, the language outside the parenthetical is unambiguous. It says without qualification that the subsection applies to "provisions . . . concerning the reporting and withholding of taxes." And the language inside the parenthetical, prefaced with the word "including," literally says the same. To "include" is to "contain" or "comprise as part of a whole." Webster's Ninth New Collegiate Dictionary 609 (1985). In this instance that which "contains" the parenthetical references – the "whole" of which the references are "parts" – is the phrase "provisions . . . concerning the reporting and withholding of taxes. . . ."

Chickasaw, 534 U.S. at 89.

possible that Telecare will be liable under the MSP statute even when it cannot seek reimbursement from Kaiser. Telecare argues Congress cannot have intended an employer who is not otherwise liable for medical expenses to actually end up paying for such expenses through reimbursing Medicare, without further recourse from an insurer. In support of this argument, Telecare notes that the same parenthetical in section 1862 that imposes liability on employers also imposes liability on TPAs, but recovery against TPAs is precluded in certain circumstances when the TPA would not be able to seek further reimbursement from "the employer or group health plan."[9] Telecare argues that Congress would not have intended to treat employers differently from TPAs, and had Congress really intended to impose liability on employers, it would have included a similar exemption from liability in cases where later recovery by the employer from the group health plan was unavailable.

There are several responses to Telecare's policy argument. First and foremost, the plain language of the statute leads to a contrary result. Second, Congress plainly regarded TPAs as appropriately falling into a

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[9] The provision states:

> The United States may not recover from a third-party administrator under this clause in cases *where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan* and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

Social Security Act § 1862(b)(2)(B)(iii), codified at 42 U.S.C.A. § 1395y(b)(2)(B)(iii) (Supp. 2004) (emphasis added).

different category than employers since TPAs were exempt only if they could not recover from either the group health plan *or the employer*. Third, it is up to Congress, and not this court, to decide whether the statute is fair to employers as compared to TPAs or insurers. *See United States v. Noland*, 517 U.S. 535, 541 n.3 (1996) ("Noland may or may not have a valid policy argument, but it is up to Congress, not this Court, to revise the [statute] if it so chooses."); *cf. HIAA*, 23 F.3d at 416-17. Finally, Telecare's concern that it will end up without reimbursement from Kaiser after paying Medicare can be remedied if Telecare enters into agreements with insurance providers that allow recourse for the same period as the government has recourse against Telecare as an employer.

V

Therefore, we hold that the statute allows the United States to initiate an action against any employer that "sponsors or contributes to a group health plan," where the group health plan "make[s] payment with respect to the same item or service (or any portion thereof) under a primary plan." Such a construction gives reasonable meaning and effect to all the words in the statute, and is to be preferred over Telecare's proposed interpretation, which would render parts of the statute inoperative. Telecare sponsors and contributes to the group health plan, and under the plain language of the statute it cannot prevail.

CONCLUSION

For the foregoing reasons, the judgment of the district court is affirmed.

AFFIRMED.

COSTS

No costs.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

TELECARE CORP., on behalf of itself and others similarly situated,

Plaintiffs,

v.

TOMMY G. THOMPSON, Secretary of Health and Human Services, et al.,

Defendants. /

No. C 03-3797 SBA

ORDER

[Docket No. 21]

This matter comes before the Court on Defendants' motion to dismiss or in the alternative for summary judgment [Docket No. 21].[1] Having read and considered the papers submitted by the parties, and the arguments of counsel at a hearing on February 24, 2004, the Court hereby GRANTS Defendants' motion to dismiss.

Plaintiffs' complaint is based on an attempt by the Health Care Financing Administration ("HCFA"), now

[1] Plaintiffs filed an objection to Defendants' exhibits C, D, E on the grounds that they were unauthenticated. Plaintiffs further objected to Defendants' exhibits C and D as hearsay. Defendants' exhibit E is also attached to Plaintiffs' Cruz Decl. Exh. 10. With respect to Defendants' exhibits C and D, Defendants filed additional declarations authenticating the exhibits. Furthermore, exhibits C and D are not hearsay because the documents are not offered to establish the truth of their contents but merely that the communications occurred. Accordingly, Plaintiffs' objection is overruled.

Plaintiffs further objected to portions of Defendants' exhibit B. The Court did not consider the portions of exhibit B that Plaintiffs objected to and so Plaintiffs' objection is overruled as moot.

known as the Centers for Medicare and Medicaid Services ("CMS"), to obtain reimbursement under the Medicare as Secondary Payer statute. 42 U.S.C. § 1395y(b)(2). The Court's jurisdiction is premised on 28 U.S.C. §§ 1331 and 1346(a)(2) and 5 U.S.C. § 702 (the "Adminstrative Procedures Act" or "APA"). Compl. ¶ 9.

Plaintiff is a corporation which sponsors a group health plan for its employees within the meaning of 26 U.S.C. § 5000(b)(1) (incorporated by 42 U.S.C. § 1395y(b)(1)(A)(v)). In circumstances where a patient is covered by both an employer group health plan and Medicare, the "Medicare Secondary Payer" statute ("MSP") mandates that the group health plan is the primary payer and any payment for medical services erroneously paid for by Medicare is subject to recoupment. 42 U.S.C. §§ 1395y(b)(2)(A)(i), (2)(B)(i). The Secretary of Health and Human Services (the "Secretary") is authorized to recover such overpayments from "any and all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health, or large group health plan, or otherwise) to make payment "with respect to" a Medicare-covered service "under a primary plan." Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Prescription Drug Act"), § 301(b)(3) (to be codified at 42 U.S.C. § 1395y(b)(2)(B)(iii)). Deeming Plaintiff Telecare Corp. ("Telecare") to be such a responsible entity, the Secretary demanded repayment of $1,342.40 in connection with medical services provided to an individual covered by Telecare's group health plan. Telecare paid the money, plus interest, under protest, and now seeks to recover it, pursuant to the "Little Tucker Act," 28 U.S.C. § 1342(a)(2). Pursuant to the Administrative

Procedure Act ("APA"), 5 U.S.C. §§ 701-706, Telecare, on behalf of itself and others similarly situated, also seeks to enjoin the Secretary from demanding such repayments from it in the future.

A. Plaintiffs' APA Claims

At the outset, Plaintiffs' claims brought under the APA ("APA claims") must be dismissed for lack of subject-matter jurisdiction.

1. Waiver of Sovereign Immunity

"Absent a waiver, sovereign immunity shields the Federal Government and its agencies from suit." *FDIC v. Meyer*, 510 U.S. 471, 475 (1994); *see Department of the Army v. Blue Fox, Inc.*, 525 U.S. 255, 260 (1999); *Consol. Edison Co. of N.Y. v. United States*, 247 F.3d 1378, 1382 (Fed. Cir. 2001); *Tucson Airport Authority v. General Dynamics Corp.*, 136 F. 3d 641, 644-45 (9th Cir. 1998). The APA waives sovereign immunity only if three conditions are met: (1) Plaintiffs' APA claims are for relief "other than money damages," (2) an adequate remedy for Plaintiffs' APA claims is not available elsewhere and (3) Plaintiffs' APA claims do not seek relief expressly or impliedly forbidden by another statute. *Tucson Airport Auth. v. General Dynamics Corp.*, 136 F.3d 641, 645 (9th Cir. 1998). A waiver of sovereign immunity is to be strictly construed, in terms of its scope, in favor of the sovereign. *Blue Fox*, 525 U.S. at 261

The Court finds that Plaintiffs' APA claims are not claims for relief "other than money damages." *See generally Blue Fox*, 525 U.S. 255. To the extent that Plaintiffs'

APA claims are claims for relief "other than money damages," the availability of a claim for monetary relief under the Little Tucker Act establishes that there is another adequate "remedy in court." 5 U.S.C. § 704; *see Consol. Edison*, 247 F.3d at 1382-85. Therefore, the Court finds that it lacks jurisdiction over Plaintiffs' APA claims because the APA does not waive Defendants' sovereign immunity as to any of these claims.

2. Ripeness

Moreover, even if the Court were to find that the APA waived Defendants' sovereign immunity for Plaintiffs' APA claims, the Court still lacks subject matter jurisdiction over them due to lack of ripeness. In evaluating ripeness, courts assess "both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." *Association of Am. Med. Colleges v. United States*, 217 F.3d 770, 779-80 (9th Cir. 2000).

a. First Prong

Under the first prong, "agency action is fit for review if the issues presented are purely legal and the regulation at issue is a final agency action." *Id.* at 780. The Ninth Circuit has enunciated the following relevant factors: (1) whether the administrative action is a definitive statement of an agency's position; (2) whether the action has a direct and immediate effect on the complaining parties; (3) whether the action has the status of law; and (4) whether the action requires immediate compliance with its terms. *Id; see FTC v. Standard Oil Company*, 449 U.S. 232, 239 (1980).

With respect to the first factor, the CMS did not issue any regulation that Plaintiffs are currently challenging. Indeed, Plaintiffs concede that the challenged interpretation "was developed not in a regulation but as a series of form letters and internal directives to CMS staff and private collections agencies." Plaintiffs' Opp. at 18. But the dunning letters are not definitive statements that Plaintiffs are liable for repayment. The letters merely state that the agency has *reason to believe* the recipient is liable for this debt, but it is not definitive on the actual charges and violations. Cruz Decl. Exhs. 4, 5; *see Standard Oil*, 449 U.S. at 241. And even though the letters request a specific repayment amount, they provide various alternatives and procedures for resolving the matter. Cruz Decl. Exhs. 4, 5. Because these letters do not consummate the agency's decision making process, these letters are not a definitive statement of the agency's position.

Second, the agency's decision to pursue claims against Plaintiffs, and the actual dunning letters themselves, do not have a direct and immediate effect on Plaintiffs. While the letters did inform Plaintiffs that they were liable for a debt, the action did not impose an obligation, deny a right, or fix some legal relationship as a consummation of the administrative process. *Ukiah Valley Medical Center v. FTC*, 911 F.2d 261, 264 (9th Cir. 1990), *quoting Chicago & S. Air Lines, Inc. v. Waterman S.S. Corp*, 333 U.S. 103, 113 (1948). As discussed, *supra*, the letters contain specific steps for Plaintiffs to take to challenge the claim and to show that they are not liable for repayment. This includes "the right to present evidence that all or part of your debt is not . . . legally enforceable." Cruz Decl. Exh. 5. Thus, the dunning letters are clearly not the consummation of the administrative process. *See Standard Oil*, 449 U.S. at 242.

Finally, the dunning letters do not have the status of law with the expectation of immediate compliance. In contrast, in *Abbott Labs. v. Gardner*, 387 U.S. 136 (1967), the Supreme Court found that the regulation required immediate compliance by the manufacturers. *Id.* at 152-53. The alternative to compliance would subject the company to civil and criminal penalties. *Id.* at 153; *see also Standard Oil*, 449 U.S. at 242. Here, the letters clearly delineate the administrative procedures that may be taken in order to challenge the debt. Cruz Decl. Exhs. 4, 5. The employer may also choose to ignore the recovery demand letter and ignore the Notice of intent letter. *Id.* "Any 'consequences' Plaintiffs claim to have suffered or to be suffering as a result of their procedural wrangling with Defendants [did] not constitute direct and immediate impacts because they [did] not impose any appreciable obligations upon their daily business." *Mobil Exploration v. Department of Interior*, 180 F.3d 1192, 1203 (10th Cir. 1999).

b. Second Prong

Under the second prong, "it must be shown that withholding review of the issue would result in direct and immediate hardship and would entail more than possible financial loss." *Anchorage v. United States*, 980 F.2d 1320, 1325-1326 (9th Cir.1992). "'[F]or an institutional interest in deferral to be outweighed, postponing review must impose a hardship on the complaining party that is *immediate, direct,* and *significant.*'" *Id.* at 1326, citing, *National Ass'n of Reg. Util. Com'rs v. Dept. of Energy*, 851 F.2d 1424, 1429 (D.C. Cir. 1988) (emphasis in original). Thus, ripeness will prevent review if the systemic interest in postponing adjudication due to lack of fitness outweighs

the hardship on the parties created by postponement. *Anchorage v. United States*, 980 F.2d 1320, 1323 (9th Cir. 1992) (citation omitted).

With respect to the second prong of the ripeness analysis, the Court finds that withholding review would not result in direct and immediate hardship. The Ninth Circuit circumscribed the rule in *Abbott Labs* "to regulations that pose an immediate dilemma." *Association of American Medical Colleges*, 217 F.3d at 783. As discussed, *supra*, these letters are not a regulation issued by CMS. Furthermore, a requirement to participate in a administrative proceeding to respond to these letters do not pose an immediate dilemma. As the Supreme Court stated in *Standard Oil* "[a]lthough this burden certainly is substantial, it is different in kind and legal effect from the burdens attending what heretofore has been considered to be a final action." 449 U.S. at 242. The Supreme Court noted, "the expense and annoyance of litigation is part of the social burden of living under government." *Id.* at 244. There is no basis for treating the expense and annoyance of responding to these letters any differently.

Furthermore, any hardship that Plaintiffs may face is not outweighed by the systemic interest in postponing adjudication due to lack of fitness. In *Standard Oil*, the Supreme Court found that the effect of judicial review sought by the plaintiff was likely to interfere with the proper functioning of the FTC and be a burden for the courts that "would serve neither efficiency nor enforcement of the Act." *Standard Oil*, 449 U.S. at 242. Similarly, in this case, judicial review would just interfere with the proper functioning of the CMS. The letters clearly state the administrative procedure that alleged debtors are to follow to challenge the debt. Cruz Decl. Exhs. 4, 5. And

those procedures have worked in this case because Telecare has been able to obtain refunds for all of the debt that it claims was improperly levied. Cruz Decl. ¶ 14, Exh. 11. Judicial intervention would at this stage would serve neither the efficiency nor enforcement of the MSP statutes.

In light of the foregoing analysis, the Court finds that there is no final agency action and that the issues presented are not ripe for review. Furthermore, the Court finds that the systemic interest in postponing adjudication due to lack of fitness outweighs the hardship on the parties created by postponement. *Anchorage*, 980 F.2d at 1323. Thus, the Court lacks subject matter jurisdiction over Plaintiffs' APA claims.

B. Plaintiffs' Little Tucker Act Claims

Plaintiffs' remaining claims brought under the Little Tucker Act must also be dismissed for failure to state a claim. As recently amended, the Medicare Secondary Payer statute expressly provides that "the United States may bring an action against any and all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health, or large group health plan, or otherwise) to make payment "with respect to" a Medicare-covered service "under a primary plan." Medicare Prescription Drug Act, § 301(b)(3) (to be codified at 42 U.S.C. § 1395y(b)(2)(B)(iii)). It is not disputed that Telecare is "an employer that sponsors or contributes to a group health plan." As such, Telecare is required to guarantee that payment for medical services for its employees is made under such a plan in accordance with the non-discrimination and no-carve-out provisions in

42 U.S.C. §§ 1395y(b)(1)(A)(i)(I), (II). An employer that fails to meet these requirements maybe held responsible for a tax penalty. 26 U.S.C. § 5000(a). An employer that sponsors or contributes to a group health plan therefore falls squarely within the language of the statute, and the Secretary's regulations properly make such employers liable for repayment. 42 C.F.R. § 411.24(e); *see Health Insurance Association of America v. Shalala*, 23 F.3d 412, 416 (D.C. Cir. 1994). At the very least, the Secretary's construction of the statute is sufficiently reasonable to be accorded deference. *Barnhart v. Walton*, 535 U.S. 212, 218 (2002) (deference afforded to agency's regulations); *Christensen v. Harris County*, 529 U.S. 576, 587 (2000) (deference afforded to agency's interpretations that lack the force of law).

The foregoing analysis supports a finding that an employer that sponsors or contributes to a group health plan is an entity that is "required or responsible" to make payment "with respect to" a Medicare-covered service "under a primary plan." Accordingly, the Court finds that CMS may properly seek Medicare overpayments from such employers.

Good cause appearing,

IT IS HEREBY ORDERED THAT Defendants' motion to dismiss is GRANTED.

IT IS SO ORDERED.

/s/ Saundra Brown Armstrong
SAUNDRA BROWN ARMSTRONG
United States District Judge

Dated: 4/23/04

42 U.S.C. § 1395y

* * *

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan –

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of Title 26.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of Title 26, without regard to section 5000(d) of Title 26.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v)) –

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the 12-month

period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426-1 of this title; or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997, (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of Title 26) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of Title 26) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of Title 26.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) Current employment status defined

An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an

automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Repayment required

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations): Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Primary plans

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under

this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditions upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any

portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of Title 26.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a, primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but –

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed –

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis –

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINS of medicare beneficiaries (as defined in section 6103(*l*)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator –

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(*l*)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such Intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(*l*)(12)(E)(iii) of such title), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse maybe (or have been) covered under a group health plan of the employer and the nature of the coverage

that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A of this subchapter or enrolls under part B of this subchapter, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B of this subchapter unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

[Plaintiffs Complaint]

EXHIBIT A

Terry Beckham, Data Match Supervisor
MSP Department

Enclosures:
MSP Summary Data Sheet
Summary of Medicare Payments
Claims Facsimiles
Important Information for Employers
######

Important Information for Employers

Employers often ask us to explain why an employer, especially one who purchases insurance from an insurance company, has or shares liability for this debt and to explain the potential consequences if the employer fails to resolve this matter. We provide these explanations in this enclosure.

Congress has created a statutory framework in the Medicare statute and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. One of Medicare's regulations, 42 C.F.R. 411.24(e), provides that "HCFA has a direct right to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier,

plan or program . . . " Accordingly, Medicare may seek recovery from the employer.

The MSP provisions generally require group health plans to make payments primary to Medicare for: (1) individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and (2) individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a thirty-month coordination period if the individual is covered under a group health plan on any basis. A group health plan is defined in the Internal Revenue Code at 26 U.S.C. section 5000(b) as a "plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families." Taken together, the MSP provisions and the Internal Revenue Code definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's compliance with the MSP rules.

Employer accountability is also reflected by Internal Revenue Code provisions allowing the employer to claim health plan expenditures as a deductible business expense (26 U.S.C. 162), and subjecting the employer to an excise tax if a plan to which it contributes does not conform to the MSP provisions (26 U.S.C. 5000(a) and (b)). Employers create, direct, authorize and control their health plans. Where an employer establishes a plan to provide health benefits indirectly through insurance, the employer determines the nature of the coverages and has the right

to enforce its insurance contract to assure compliance with applicable laws.

Courts have also recognized that an employer is an entity responsible for payment. In Provident Life and Accident Insurance Co. v. United States, 740 F. Supp. 492, 504 (E.D. Tenn. 1990), the court concluded "that the Government must look to the employer or other entity who actually insures the employee" to recover Medicare overpayments in MSP situations. Also, in United States v. Blue Cross and Blue Shield of Michigan, 726 F. Supp. 1517, 1521 (E.D. Mich. 1989), the court agreed that "the employer at all times is the entity which undertakes full 'financial responsibility for payments' under the plan, i.e., the employer is the one who bears the cost of administering and financing the plan." In 1994, a court held that, if a group health plan is administered by a third party administrator, Medicare must seek to recover its mistaken payment from the employer or plan itself. In Health Insurance Association of America v. Shalala, 23 F.3d 412, 416 (D.C. Cir. 1994), the court of appeals held that third party administrators could not be subjected to recovery actions because they "assume no financial responsibility for paying a plan's benefits."* Because the employer or the plan are the entities that have financial responsibility, they are the entities from which Medicare must seek payment.

Regulations under the Federal Claims Collection Act establish that all entities responsible for paying a debt to

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* Portions of this decision, limiting the Government's ability to collect from TPA's and subjecting the Government to a plan's time limits for filing claims, were reversed by recent legislation effective for services furnished on or after August 5, 1997.

the Federal Government are jointly and severally liable for payment of the debt. As previously explained, the employer is one of potentially several entities responsible for making primary payment under the MSP provisions. If the United States must take legal action to recover this debt, the Government may take action against any or all entities responsible for payment, including the insurer, the plan and the employer (See 42 U.S.C. 1395y(b)(2)(B)(ii); and 42 C.F.R. 401.623.) If the Government is unable to recover the total debt from one of the entities responsible for payment, it may then pursue recovery from another.

If an employer does not repay Medicare or arrange for Medicare to be paid in full, any tax refunds that may be due the employer under the Internal Revenue Code may be applied toward satisfaction of the MSP debt (31 U.S.C. 3720A). In addition, the MSP provisions state that a plan that does not repay Medicare may be held to be a "nonconforming" plan (See 42 U.S.C. 1395y(b)(3)(B) and 42 C.F.R. 411.100 et seq.) The Internal Revenue Code at Section 5000 imposes a 25 percent excise tax on all employers, except government entities, on all health plan expenditures of employers and employee organizations that contribute to a nonconforming group health plan. A plan may be found to be nonconforming both in the year that it failed to repay Medicare and in the year in which it was originally obligated to have made primary payment. In addition, the Debt Collection Improvement Act of 1996 (Chapter 10 of P.L. 104-134) requires Federal Agencies to collect debts by offset from any monies otherwise payable to the debtor by the United States.

3

Supreme Court, U.S.
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No. 05-263

In the Supreme Court of the United States

TELECARE CORP., PETITIONER

v.

MICHAEL O. LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Petitioner is a corporate employer that sponsored and contributed to an employee group health plan by purchasing third party health insurance for its employees. The question presented is whether petitioner is required under the Medicare Secondary Payer statute, 42 U.S.C. 1395y(b)(2)(B)(iii), to reimburse the United States when the United States makes payment under the Medicare program for items or services also covered by petitioner's employee group health plan.

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BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-21a) is reported at 409 F.3d 1345. The order of the district court (Pet. App. 22a-30a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on May 25, 2005. The petition for a writ of certiorari was filed on August 23, 2005. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

This case concerns the interpretation of amendments to the Medicare Secondary Payer statute that were en-

acted in 2003, while this case was pending in the district court.

1. For the first fifteen years of the Medicare program's existence, Medicare generally paid for services regardless of whether another insurance plan might also be responsible to pay for the beneficiary's care. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862(b), 79 Stat. 325. Beginning in 1980, however, Congress enacted a series of amendments designed to make Medicare the secondary rather than the primary payer for its beneficiaries when certain other insurance was available. The amendments have been codified at 42 U.S.C. 1395y(b) and are known as the Medicare Secondary Payer (or MSP) statute.

As the courts of appeals have explained, "[t]he transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs." *United States* v. *Baxter Int'l, Inc.*, 345 F.3d 866, 874-875 (11th Cir. 2003) (quoting *Zinman* v. *Shalala*, 67 F.3d 841, 845 (9th Cir. 1995)), cert. denied, 542 U.S. 946 (2004). The "obvious and express purpose" of the MSP statute is to "'reduc[e] federal health care costs' by making 'Medicare's payments . . . secondary and subject to recoupment in *all* situations where one of the statutorily enumerated sources of primary coverage could pay instead.'" *Brown* v. *Thompson*, 374 F.3d 253, 260 (4th Cir. 2004) (quoting *Baxter*, 345 F.3d at 888).

To effectuate that goal, the MSP statute broadly defines the circumstances under which Medicare is secondary to other insurance and the circumstances under which reimbursement of Medicare payments must be made. As the Eleventh Circuit explained, "[s]ince enacting the MSP statute, Congress has expanded its reach

several times, making Medicare secondary to a greater array of primary coverage sources, and creating a larger spectrum of beneficiaries who no longer may look to Medicare as their primary source of coverage." *Baxter*, 345 F.3d at 877. In addition, "Congress has repeatedly clarified and augmented the Government's powers to recoup conditional Medicare payments from primary sources." *Ibid.*

This case concerns the liability of an employer that sponsors or contributes to a group health plan to reimburse Medicare for mistaken payments for which the group health plan was primarily liable. Paragraph (1) of the MSP statute imposes substantive requirements on employers that choose to sponsor or contribute to group health plans. The statute's non-discrimination provision requires that an employer's group health plan (other than the plan of a small employer) provide the same benefits under the same conditions to employees (and spouses) age 65 or older as the plan provides to employees (and spouses) under 65. 42 U.S.C. 1395y(b)(1)(A)(i)(II) and (ii). Similarly, the statute's no-carve-out provision bars an employer's group health plan (other than the plan of a small employer) from taking into account the fact that an employee (or spouse) age 65 or older is entitled to Medicare benefits. 42 U.S.C. 1395y(b)(1)(A)(i)(I).

An employer that abides by the non-discrimination and no-carve-out mandates of the MSP statute is entitled to deduct the business expenses incurred in connection with the group health plan from its revenues in computing taxable income. If, however, the employer fails to meet those requirements, its group health plan may be deemed nonconforming, 26 U.S.C. 5000(c), and the employer may be assessed an excise tax equal to

25 percent of the expenses incurred by the employer in connection with any plan during the calendar year, 26 U.S.C. 5000(a).

Paragraph (2) of the MSP statute sets out directives to ensure that Medicare's coverage is secondary to the employer group health plan coverage required under paragraph (1) (as well as to the coverage of other forms of insurance not at issue in this case, such as liability and automobile insurance). Paragraph (2) directs the Medicare program not to pay for benefits when payment for the item or service has been made, or can reasonably be expected to be made, under an employer group health plan. 42 U.S.C. 1395y(b)(2)(A)(i).

Congress recognized that, in practice, the Medicare program often lacks the information needed to determine whether to make payment under the Medicare program. See, *e.g.*, *Baxter*, 345 F.3d at 901 n.30 ("HHS and Congress have repeatedly flagged Medicare's inability to ascertain the existence of alternative sources of coverage as a weakness in the secondary payer program."). Accordingly, Congress has authorized the United States to seek recovery from a wide range of entities with responsibility for making payment in connection with a primary insurance plan. The statute, in its present form, authorizes the United States to bring an action for reimbursement against:

> any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, *as an employer that sponsors or contributes to a group health plan*, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.

42 U.S.C. 1395y(b)(2)(B)(iii) (emphasis added). Thus, "an employer that sponsors or contributes to a group health plan" may be required to reimburse Medicare, regardless of whether the employer had "direct[]" responsibility for making payment in the normal course for services provided to covered individuals under the plan.

The above underscored language was enacted (along with other amendments to the MSP statute) in 2003, while this case was pending in district court. Medicare Prescription Drug Act, Pub. L. No. 108-173, § 301, 117 Stat. 2221. As petitioner conceded below (Pet. C.A. Br. 18-19 & n.9), the amendments were intended to clarify rather than to change the law, and thus govern all of plaintiff's claims. Indeed, Congress formally declared that the amendments were "[c]larifying," 117 Stat. 2221, and provided that the amendments were effective as if included in the MSP statute as originally enacted in 1980, 117 Stat. 2222; see *Brown* v. *Thompson*, 374 F.3d 253, 259-260, 261-262 (4th Cir. 2004) (holding that the 2003 amendments clarified rather than changed the law).

2. a. Petitioner is a corporate employer that sponsored and contributed to a group health plan for its employees. According to the complaint, from 1996 to 2002, plaintiff maintained a group health plan within the meaning of the Medicare Secondary Payer statute by purchasing third-party health insurance for its employees from Kaiser Foundation Health Plan. C.A. App. 21 (Compl. ¶ 3).

The complaint alleged that petitioner could not be required to reimburse the Medicare program for Medicare payments made for items or services covered by petitioner's group health plan. C.A. App. 27 (Compl.

¶¶ 39-40). In petitioner's view, only employers that maintain self-insured group health plans may be required to reimburse the Medicare program. See *ibid.* Because petitioner's group health plan was underwritten by a third-party insurer (Kaiser) rather than self-insured, petitioner alleged that it could not be required to reimburse Medicare. *Ibid.* The complaint sought the return of $1342.40 that petitioner had paid the Medicare program under protest, C.A. App. 25 (Compl. ¶¶ 27-29), as well as declaratory and injunctive relief.

b. As stated, while this case was pending in district court, Congress amended the MSP statute to state expressly that "an employer that sponsors or contributes to a group health plan" may be required to reimburse Medicare, regardless of whether the employer's responsibility for the plan's payments was derived "directly" or "otherwise." 42 U.S.C. 1395y(b)(2)(B)(iii). The district court held that under the plain terms of those amendments, petitioner could be required to reimburse the Medicare program for items or services covered under petitioner's group health plan. Pet. App. 29a-30a. Accordingly, the district court granted the government's motion to dismiss the complaint. *Id.* at 30a.

c. A unanimous panel of the Federal Circuit affirmed. The court of appeals agreed with the district court that "the statute's plain language compels a finding that all employers who sponsor or contribute to a group health plan are liable." Pet. App. 13a. The court rejected petitioner's contention that only self-insured employers may be held liable, explaining that Congress had "separately provided for recovery from self-insurers in the same statutory provision," *ibid.*, and that petitioner's interpretation thus "would render parts of the statute inoperative," *id.* at 20a. The court also rejected

petitioner's related contention that employers that do not self-insure cannot be regarded as "required or responsible * * * to make payment" under a plan. *Id.* at 13a. The court explained that the statute expressly contemplates that an entity's responsibility for payment may be felt "directly" or "indirectly," *id.* at 16a, and observed that even an employer whose plan is underwritten by a third-party insurer retains a degree of accountability for the plan's payments, see *ibid.* Finally, the court rejected petitioner's various policy arguments, noting that petitioner's concerns could be addressed by contract with the insurance provider that underwrites the employee group health plan. *Id.* at 20a.

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or of another court of appeals. Indeed, no other court of appeals has addressed the provision of the 2003 amendments at issue in this case. The petition for a writ of certiorari therefore should be denied.

1. Petitioner argues that the MSP statute creates a cause of action against only those entities that are directly and contractually obligated to pay for the costs of medical care also covered by Medicare. It accordingly argues that employers such as itself, *i.e.* those that sponsor a primary insurance plan, cannot be liable under the statute unless the employer is self-insured and thus obligated to pay for the cost of health care. Pet. 7-14. That contention is belied by the text of the 2003 amendments to the MSP statute, which applies to any entity that is "required *or responsible* (*directly*, as an insurer or self-insurer, [or] * * * *as an employer that sponsors or contributes to a group health plan*, * * * *or otherwise*)

to make payment" with respect to an item or service covered under Medicare. 42 U.S.C. 1395y(b)(2)(B)(iii) (emphasis added).

Congress thus expressly provided that "an employer that sponsors or contributes to a group health plan" may be required to reimburse Medicare, regardless of whether the employer's responsibility for the plan's payments is felt "directly" or "otherwise," and regardless of whether the employer was "required" itself to make the payment in the normal course of business. 42 U.S.C. 1395y(b)(2)(B)(iii). With those amendments, Congress ratified the agency's preexisting regulation that imposes liability on an employer that sponsors or contributes to an employee group health plan, without regard to whether the plan was self-insured or underwritten by a third-party insurer. 42 C.F.R. 411.24(e) (explaining that the United States has a direct right of action against, *inter alia*, "an employer," "an insurance carrier," and "a third party administrator," without regard to whether the entity was contractually or directly required to pay for the cost of medical care); see also C.A. App. 34.

There is no dispute that petitioner sponsored and contributed to an employee group health plan. And as discussed above (at 3), even where an employer such as petitioner has, by contract, shifted to an insurance company the responsibility for paying the claims for services to those individuals covered by a group health plan, the employer sponsoring or contributing to the plan remains responsible for payment being made in a manner that comports with the requirements of the MSP statute. See also Pet. App. 15a-16a. Accordingly, under the plain terms of 42 U.S.C. 1395y(b)(2)(B)(iii), petitioner is required to reimburse the Medicare program if Medicare

makes a payment for an item or service also covered under petitioner's employee group health plan.

As the court of appeals explained (Pet. App. 13a-14a), petitioner's contention (Pet. 12-13) that only self-insured employers may be required to reimburse Medicare would make the provision's separate reference to "self-insured" entities superfluous. In an attempt to give meaning to the phrase "an employer that sponsors or contributes to a group health plan," petitioner argues (Pet. 13) that Congress intended the phrase to refer to "self-insuring nonprofit or charitable" employers since self-insurers are limited to only for-profit business. The statute says nothing of the sort. The statute merely "deem[s]" an entity engaged in a business, trade, or profession (without specifying whether they operate for profit or not for profit) to be self-insured when it carries its own risk; the statute does not bar charitable organizations (or for that matter any other entity) from becoming a self-insurer, or otherwise provide a limiting definition for a self-insurer. 42 U.S.C. 1395y(b)(2)(A). In any event, had Congress wanted simply to impose liability on a separate category of "non-profit self-insurers," it could have easily done so and would not have used the quite different phrase "an employer that sponsors or contributes to a group health plan." 42 U.S.C. 1395y(b)(2)(B)(iii).

Petitioner and its amici advance a variety of policy objections to the 2003 amendments, suggesting that they impose new costs on employers that sponsor or contribute to employee group health plans. But the objections misunderstand the statutory scheme. Although petitioner and its amici focus on perceived harm to small employers, the plans of small employers are exempt from the statute's requirements. 42 U.S.C.

1395y(b)(1)(A)(ii). Moreover, even for employers that are covered, an employer is always free to arrange by contract to have its third-party insurer reimburse Medicare directly and thus satisfy the employer's obligation to Medicare. Likewise, an employer is free to negotiate with its third-party insurer for an indemnity for any MSP liability. What the employer may not do, as the 2003 amendments confirm, is relieve itself by contract with a third-party insurer of any responsibility to reimburse the Medicare program when Medicare makes payment for items or services also covered under the employer's group health plan.

2. The panel's decision does not conflict with a decision from any other court of appeals. Indeed, no other court of appeals has addressed the provision of the 2003 amendments at issue in this case. All of the court of appeals decisions that petitioner cites (Pet. 9-10) were decided before Congress enacted the 2003 amendments. Moreover, none of those cases addressed the question presented here: whether an employer that sponsors or contributes to an employee group health plan by purchasing third-party insurance may be required to reimburse Medicare. In *United States* v. *Baxter Int'l, Inc.*, 345 F.3d 866 (2003), cert. denied, 542 U.S. 946 (2004), the Eleventh Circuit sustained the government's right under the MSP statute to seek reimbursement from the manufacturers of breast implants that had settled mass tort litigation. In *Mason* v. *American Tobacco Co.*, 346 F.3d 36 (2003), cert. denied, 541 U.S. 1057 (2004), the Second Circuit rejected an attempt by private individuals to sue tobacco manufacturers under the MSP statute. In *Health Ins. Ass'n of America, Inc.* v. *Shalala*, 23 F.3d 412 (1994), cert. denied, 513 U.S. 1147 (1995), the D.C. Circuit held that the government could not recover from

an insurer acting solely as the third-party administrator of an employer group health plan. That decision, however, was overridden by Congress. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4633(a), 111 Stat. 487. And *Waters* v. *Farmers Texas County Mut. Ins. Co.*, 9 F.3d 397 (5th Cir. 1993), concerned the amount that the government was entitled to recover from the proceeds of an automobile insurance policy. The only decision that does support petitioner's position is an unpublished district court decision, *Manning* v. *Utilities Mut. Ins. Co.*, No. 98 Civ. 4790(RCC), 2004 WL 235256, at *6 (S.D.N.Y. Feb. 9, 2004). The government was, moreover, not a party in that case, and the court did not discuss the 2003 amendments to the MSP statute.

Petitioner's amici suggest (Br. 16) that it would be futile to await a conflict on the issue presented here because they believe that the issue inevitably will arise in the Federal Circuit. Petitioner similarly argues (Pet. 18) that any challenge to the government's imposition of MSP liability on employers must arise in the Federal Circuit because the government may impose liability by administrative offset against those employers who may be entitled to tax refunds under 31 U.S.C. 3720A. Those arguments lack merit, and MSP cases routinely arise outside the Federal Circuit, as the cases discussed above illustrate. This case arose in the Federal Circuit because petitioner chose to make payment to Medicare under protest and then sue for a refund, see Pet. App. 3a, 5a. Moreover, in any case where offset is unavailable (*i.e.*, because the employer is not entitled to receive money from the Treasury), the government would have to sue in the federal district court where the employer resides. 28 U.S.C. 1391(b).

Moreover, the issue of whether employers such as petitioner are liable may arise in cases where the government is not a party. The MSP statute creates a private cause of action against any primary plan (such as the group health plan sponsored by petitioner, see 42 U.S.C. 1395y(b)(2)(A), that refuses to make primary payment). 42 U.S.C. 1395y(b)(3)(A). The only other case to address the precise issue presented here arose in the Southern District of New York when a beneficiary argued that an employer such as petitioner was responsible for making payment under a primary plan. See *Manning*, 2004 WL 235256, at *6. There is therefore no reason to think that if the issue is important and recurring it will not arise in other courts of appeals.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted.

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TELECARE CORP.,

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MIKE LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND CENTER FOR MEDICARE AND MEDICAID SERVICES,

Respondents.

On Petition For A Writ Of Certiorari To The Court Of Appeals For The Federal Circuit

BRIEF *AMICI CURIAE* OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND NATIONAL FEDERATION OF INDEPENDENT BUSINESS LEGAL FOUNDATION IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

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INTEREST OF *AMICI CURIAE*[1]

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation representing an underlying membership of nearly three million businesses, state and local chambers of commerce, and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of the national business community by filing *amicus curiae* briefs in cases involving issues of concern to American business.

The National Federation of Independent Business Legal Foundation ("NFIB Legal Foundation"), a nonprofit, public interest law firm established to protect the rights of America's small-business owners, is the legal arm of the National Federation of Independent Business (NFIB). NFIB is the nation's oldest and largest organization dedicated to representing the interests of small-business owners throughout all 50 states. The approximately 600,000 members of NFIB own a wide variety of America's independent businesses from restaurants to manufacturing firms to bowling alleys.

The membership of the Chamber and NFIB has an interest in this case because many of them maintain medical benefit plans covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). They are vitally interested in preserving the

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[1] Pursuant to Sup. Ct. Rule 37.6, *amici* represent that counsel for a party did not author this brief in whole or in part, and no person or entity other than the *amici*, their members and their counsel made a monetary contribution to the preparation or submission of this brief.

freedom afforded them under ERISA to cap their exposure to liability under such plans by purchasing insurance. In addition, the Chamber and NFIB wish to bring to the Court's attention an important fact that may have been overlooked in the court below but that unlocks the statutory provision at issue.

Both petitioner and respondents have consented to the filing of this brief. The parties' letters of consent are being filed simultaneously with this brief.

STATEMENT OF THE CASE

Petitioner maintains an employee welfare benefit plan under ERISA that consists of purchasing medical insurance for its eligible employees. The benefit promised by the plan is the payment of premiums on the medical insurance; petitioner has no liability under terms of the plan to reimburse employees for medical expenses.

A beneficiary under petitioner's plan incurred an expense for which the beneficiary was entitled to reimbursement under the plan from the insurance company. Instead, Medicare paid the expense by mistake. Respondents, including the administrator of the Medicare program, sought reimbursement from petitioner, relying on the Medicare Secondary Payer program, codified at 42 U.S.C. § 1395y(b)(2), which requires reimbursement by "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service . . . under a primary plan."

Having no success at convincing respondents that petitioner was not an entity that was required or responsible

to make payment under petitioner's plan, petitioner paid and sued respondents for a refund. The United States District Court for the Northern District of California dismissed the complaint. The U.S. Court of Appeals for the Federal Circuit affirmed (409 F.3d 1345), holding that all employers who maintain insured medical plans are *ipso facto* "responsible" for reimbursements under such plans and therefore liable to reimburse Medicare for any mistaken payments made by Medicare.[3]

REASONS FOR GRANTING THE WRIT

The Federal Circuit framed the question as "either/or": either all employers with insured medical plans are exposed to liability under Medicare Secondary Payer or none are. Concluding that neither alternative exactly squared with the statutory language, it chose what it perceived as the lesser of two evils.

What the decision below overlooked is the fact that some employers with insured medical plans still bear ultimate financial liability for the benefits (notwithstanding the insurance), while other employers with insured medical plans promise only to pay insurance premiums, not to provide the ultimate medical benefits. The latter approach is not only permitted by ERISA but vital to

[3] Specifically, the Federal Circuit held that "responsible" under the statute includes any "degree of accountability," and all employers who sponsor or contribute to medical insurance plans have a "degree of accountability." App. at 16a. The Federal Circuit made no effort to explain the source or nature of this "degree of accountability" in the face of petitioner's allegation, which the court accepted as true, that petitioner bore no financial responsibility to employees under its plan beyond the payment of premiums on medical insurance, and thus had no liability to reimburse employees for eligible medical expenses.

enable small businesses to cap their exposure at the premium paid.

With that understanding, a more nuanced view of the statute is possible and suddenly the language of the statute makes perfect sense: employers with insured medical plans who bear ultimate financial liability for the benefits may be liable under Medicare Secondary Payer (just as they would have been liable for the benefits if no mistake had been made), whereas employers who have limited their commitment to paying premiums (and thus would not have been liable for the benefits even if no mistake had been made) are not liable under Medicare Secondary Payer.

It is important that the Court correct this error for two reasons. First, the decision below effectively strips small businesses of the ability to protect themselves against catastrophic medical expenses through purchasing insurance and can only accelerate the trend toward elimination of medical insurance benefits among small business, contrary to public policy. Second, because of the self-help available to the government to enforce the error and because of the exclusive jurisdiction of the Federal Circuit, this Court's review may represent the only effective remedy.

A. In An Insured Medical Plan, ERISA Leaves The Employer Free To Take Ultimate Financial Responsibility For The Benefits Or Not, As the Employer Chooses.

In ERISA, Congress left employers free to define the promise that they make to employees in their employee benefit plans, focusing instead on assuring that the promise is kept. As this Court stated just last term in *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743 (2004):

> There is no doubt about the centrality of ERISA's object of protecting employees' justified expectations of receiving the benefits their employers promise them.
>
> "Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan. ERISA does, however, seek to ensure that employees will not be left empty-handed once employers have guaranteed them certain benefits. . . . [W]hen Congress enacted ERISA, it 'wanted to . . . mak[e] sure that if a worker has been promised a defined pension benefit upon retirement – and if he has fulfilled whatever conditions are required to obtain a vested benefit – he actually will receive it.'"

This is all the more true in the case of welfare benefit plans such as medical insurance plans.[3] In *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 78 (1995), this Court reiterated:

> [W]e are mindful that ERISA does not create any substantive entitlement to employer provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.

Introducing the subject of welfare benefit plans, the authoritative treatise *Employee Benefits Law*, edited by the Employee Benefits Committee of the Section of Labor

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[3] ERISA divides the universe of employee benefit plans into those which provide retirement income ("employee pension benefit plans") and those which provide other health and welfare benefits ("employee welfare benefit plans").

and Employment Law of the American Bar Association and published by The Bureau of National Affairs, Inc., sets the stage succinctly:

> Although Congress stated, when it enacted ERISA in 1974, its intent to occupy the field of regulating health, life insurance and a broad array of other nonpension benefits, and subjected state laws attempting to regulate such benefits to ERISA's broad preemption clause, ERISA subjected welfare benefit plans to virtually no substantive regulation other than the reporting and disclosure and fiduciary duty rules. Since 1974, Congress has not added to ERISA any substantive requirements on the nature or content of welfare plans other than the "continuation coverage" rules.

Id. at 944 (1991). Thus, with regard to welfare plans, Congress has left the employer free to define the particulars of any promise that it may choose to make to the employees in the plan document.[4]

When it comes to medical plans, the employer's freedom to define the promise that it makes to its employees offers two principal possibilities: (1) the employer may promise that employees will receive reimbursement for specified medical expenses or (2) the employer may promise to pay premiums to purchase medical insurance that provides reimbursement for specified medical expenses. The former is a promise of what the employee will get *out*

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[4] In this regard, welfare plans stand in contrast to pension plans. In ERISA, Congress chose to regulate pension plans with detailed substantive standards regarding, among other things, eligibility to participate in the plan, accrual of benefits ratably over time, vesting, funding, and the form and time of payment of benefits. In ERISA, Congress chose not to regulate the substance of welfare plans in the same way. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

of the plan (a form of defined benefit), whereas the latter is a promise of what the employer will put *into* the plan (a form of defined contribution), and there is a vast legal difference between those two approaches with respect to the employer's responsibility.

1. If the employer promises that employees shall receive reimbursement for specified medical expenses, the employer bears the ultimate responsibility for satisfying those expenses. The employer may fulfill that promise by reimbursing employees out of its general assets upon presentation of claims. That is the classic "self-funded" arrangement.

Alternatively, the same employer might adopt a funding mechanism such as purchasing a group medical insurance policy or establishing a trust as a matter of prudent financial planning to assure that its promise will be fulfilled.[5] The important point is that in either of those arrangements – insurance or trust – the plan still provides that the employer bears the ultimate financial responsibility for the benefits.

Such plans are most commonly found in the collective bargaining context, where the employer has entered into a collectively bargained insurance agreement that commits the employer to the bottom-line result but leaves the employer free to produce that result by insuring, self-insuring, or any other method. *See, e.g., Diehl v. Twin Disc, Inc.*, 102 F.3d 301, 310 (7th Cir. 1996) ("Rather, the Insurance Agreement obligated Twin Disc to secure a certain level of benefits, and Twin Disc presumably remained free

[5] Such a trust is the VEBA trust, technically known under the Internal Revenue Code as a voluntary employees' beneficiary association. 26 U.S.C. § 501(c)(9).

to negotiate with various insurance carriers (or to self-insure) and to impose cost-saving measures that did not substantially reduce benefits"), and *Senn v. United Dominion Industries, Inc.*, 951 F.2d 806, 810 (7th Cir. 1992) (where the collectively bargained insurance agreement provided, "The Company reserves the right to select or change the insurance carrier(s) or to self fund the negotiated group benefits"). *Cf.* the myriad of cases testing whether the employer violated the collectively bargained insurance agreement by selecting a different insurance carrier, such as *UAW v. Mack Trucks, Inc.*, 917 F.2d 107 (3d. Cir. 1990), *cert. denied*, 499 U.S. 921 (1991).

2. On the other hand, the employer may promise no more than to pay premiums to purchase medical insurance covering its employees. It is up to the employer to define the promise that it makes to the employee, after all, and many smaller employers choose to limit their promise to paying insurance premiums. In such an arrangement, the employer has not promised that the employee will receive reimbursement for certain medical expenses, only that the employee will receive paid-up insurance coverage. The nature of the promise, as set forth in the plan document, is the key.

This understanding springs from the core proposition that ERISA does not regulate the content of the promise. Because ERISA does not regulate the content of the promise, ERISA leaves an employer entirely free to limit its promise to paying premiums on insurance. If the plan document appropriately limits the employer's promise to payment of premiums, then the benefit provided by the plan is the payment of insurance premiums. As soon as the employer pays the premium, it has provided the full

benefit promised under the plan and has no further liability under the plan.[6]

Thus it is that a medical plan may be described as "insured" without establishing whether the employer bears ultimate financial responsibility for the reimbursements. If the employer has promised the bottom-line result – reimbursement of medical expenses – then the employer bears ultimate financial responsibility regardless of whether there is any insurance or trust. But if the employer has promised only to pay premiums on insurance, the employer has not promised reimbursement of expenses and thus bears no responsibility under the plan for reimbursing employees for covered medical expenses.

Not only is this latter approach permissible under ERISA, but it is vital in the interest of certain businesses, especially small business. Most small businesses cannot afford to promise reimbursement of expenses, because just one significant expense, such as open heart surgery or a premature birth, can wipe out the employer. Small businesses do not have the luxury of a large population of employees over which to spread the risk. In order to be able to provide any medical benefits at all, small businesses must be able to insure and thereby cap their exposure at the premiums paid.

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[6] As noted in the petition, the plan at issue in this case is of this latter type, where the employer's liability is expressly limited to payment of premiums. Pet. at 4.

B. Medicare Secondary Payer Imposes Liability On Only Those Employers Who Bear Ultimate Financial Responsibility For the Benefits Under Their Plans, Whether Insured or Not.

In the decision below, the Federal Circuit struggled with a question that it saw as "black or white": are all employers with insured plans exempt from Medicare Secondary Payer or are all employers with insured plans automatically subject to Medicare Secondary Payer?

Once it is understood that some employers with insured plans bear ultimate financial responsibility for reimbursement of medical expenses but others do not, a middle ground appears: Medicare Secondary Payer applies to those employers with insured plans who bear ultimate financial responsibility for reimbursement of medical expenses under their plans but does not apply to those employers who have chosen to limit their promise to the payment of premiums and therefore bear no responsibility for reimbursement of medical expenses under their plans. This middle ground harmonizes all of the words of the statute, preserves its core value, and avoids burdening employers in conflict with ERISA.

The statute permits the United States to recover from "any or all entities that are or were *required or responsible . . . to make payment* with respect to the same item or service . . . *under a primary plan*." 42 U.S.C. § 1395y(b)(2)(B)(iii) (emphasis added). Because of disagreements over the years as to who those entities might be, Congress added and then beefed up a parenthetical giving examples of entities that might be "required or responsible . . . to make payment . . . under a primary plan." That parenthetical list includes "self-insurer[s]" and also "an employer that sponsors or contributes to a group health plan." *Ibid.*

The essence of the problem confronting the Federal Circuit was that neither of the "black or white" extremes fit the statute as written:

– The view that Medicare Secondary Payer applies to self-insured employers but not to those which insure their plans is contradicted by the parenthetical list, which mentions both employers that self-insure and others who do not. Congress clearly knew that some employers self-insure, while others purchase insurance, and did not intend to exempt the latter categorically.

– The contrary interpretation (that Medicare Secondary Payer applies to all employers whether or not they insure their plans) is contradicted by the language that flanks the parenthetical. That is, the statute provides that Medicare Secondary Payer applies to entities such as those in the parenthetical who are "responsible . . . to make payment with respect to the same item or service . . . under a primary plan," but there are many employers with insured plans who are not responsible to make payment under their plans, so it cannot be said that Medicare Secondary Payer applies to all employers whether or not they insure their plans. (Such an interpretation could not be maintained without reading "that are . . . responsible . . . to make payment . . . under a primary plan" out of the statute.)[7]

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[7] In the past, respondents have relied on two district court cases (App. at 48a), but they do not stand for the proposition for which they are cited. In *Provident Life and Accident Ins. Co. v. United States*, 740 F. Supp. 492 (E.D. Tenn.1990), the court declared that the employer would bear ultimate financial responsibility if, hypothetically speaking, the plan were self-funded. In *United States v. Blue Cross and Blue Shield of Michigan*, 726 F. Supp. 1517 (E.D. Mich.1989), the court

(Continued on following page)

The middle ground harmonizes all of the words of the statute. The middle ground is that Medicare Secondary Payer applies to those employers, including those who purchase insurance, who bear ultimate responsibility for reimbursement of medical expenses under their plans but does not apply to those employers who have chosen to limit their liability to payment of premiums and therefore do not bear any responsibility for reimbursement of medical expenses under their plans. That is exactly what the statute says. Medicare Secondary Payer applies to "any and all entities that are required or responsible . . . to make payment . . . under a primary plan," including, for example, those who may be responsible "as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan."

Thus, an insured employer that nevertheless has chosen to promise the ultimate benefit of reimbursement of medical expenses under its plan can be liable under Medicare Secondary Payer. But an insured employer that has chosen to limit its liability to the purchase of insurance and thus does not bear any responsibility for reimbursement of medical expenses is not liable under Medicare Secondary Payer. All of the words of the statute are given meaning, all are given their normal meanings, and none are surplusage. In addition, that reading preserves the intent behind the statute and saves it from a fatal conflict with ERISA.

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stated that the employer bore full financial responsibility under the plan because, once again, the plan was self-funded. Neither of those cases said, even in *dicta*, that the employer always bears ultimate financial responsibility under an *insured* plan. (As shown above, that depends on the nature of the promise made by the employer in the plan document.)

As explained by the petitioner in the petition (at 2-4, 8-11), the intent behind the statute from its origin has been to assure that the entity that should have paid the expense in the first place pays it in the end. That is to say, Congress has always intended to fasten liability on the party who would have borne the cost if Medicare had not made the mistake of paying on a primary basis. Of course, that is the entity that bears ultimate financial responsibility for reimbursement of medical expenses under the terms of the plan.[8]

Nowhere in the statute or its legislative history has Congress breathed a single word about creating a *new* liability and fastening it on a party that *never was responsible* for the expenses in the first place under the terms of the plan. And yet that is the result of the decision below: employers that capped their exposure at the payment of premiums, as they are allowed to do under ERISA and must do for their own survival, now face open-ended liability for medical expenses, all depending on the vagaries of whether Medicare pays a claim by mistake and whom Medicare goes after for reimbursement.

Besides doing violence to the language of the Medicare Secondary Payer statute and the uniform intent of Congress, the decision below needlessly puts Medicare Secondary

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[8] The exception proves the rule. The exception is that Medicare may collect from a third-party administrator, which by definition does not bear ultimate responsibility for reimbursements. 42 U.S.C. § 1395y(b)(2)(B)(iii). But the exception limits that right of recovery to those situations where the third-party administrator remains entitled to reimbursement from the entity that really does bear ultimate financial responsibility. *Ibid.* Thus, the exception proves the rule that Congress always intended the liability to end up with the entity that bears ultimate financial responsibility under the terms of the plan.

Payer in conflict with ERISA. That is to say, ERISA leaves employers free to cap their liability by promising to pay premiums on insurance policies, rather than promising to provide reimbursement of medical expenses. ERISA assures employers that they control the promise and will not be held to any liability that they have not voluntarily taken on in their plans. But the decision below conjures a liability out of thin air and imposes it on the employer contrary to the terms of the employer's plan and the assurance of ERISA. An interpretation of Medicare Secondary Payer that places it in plain conflict with ERISA should be strongly disfavored.

C. Imposing a New Liability at Random on Small Business Is Exactly the Wrong Policy to Encourage Expansion of Health Insurance Coverage.

The effect of the decision below is to say to small business, "You may have thought that you were fully insured for medical expenses, so that your cost was fixed at the insurance premium. But if Medicare makes a mistake in paying a claim and chooses to come after you, you are not insured after all. Instead, you owe Medicare for the full amount of the claim. You never know when this might happen and there's nothing you can do about it."

One of the fundamental purposes of ERISA was to promote and encourage the formation of employee benefit plans. This Court has been vigilant in pursuit of that purpose, striking down decisions of lower courts that, however well intended, threatened to burden the maintenance of employee benefit plans in ways not contemplated by Congress and, ironically, lead to the elimination of employee benefit plans. *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990), *Curtiss-Wright v. Schoonejongen*, 514 U.S.

73 (1995), *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996), *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999). The decision below is such a decision.

It is bad enough that the decision below strips from small business the critical protection of insurance against medical expenses that ERISA affords to them. The more frightening aspect is that the liability is entirely unpredictable and capricious. The liability is unpredictable because there is no way of knowing in advance what claims Medicare will pay by mistake, nor whether those expenses will be large or small. The liability is capricious because Medicare at its whim may compel reimbursement from the plan, the insurance company or (according to the decision below) the employer. Any court should hesitate to interpret a statute in such a manner as to give the government, at its whim, the ability to impose liability on the employer for a mistake that the government made. How can small business reasonably be expected to guarantee the accuracy of Medicare's claims processing?

The current climate is one in which small business struggles to provide any health insurance at all. While small business is widely recognized as the engine of the U. S. economy, the percentage of small businesses that provide health insurance has actually been declining in recent years, according to authoritative studies, and the principal reason has been cost.[9] The decision below, which

[9] "While the percentage of firms offering health benefits is statistically unchanged from last year, it has declined over the last few years. Annual changes have been small, but the cumulative result is a statistically significant decline in the percentage of firms offering health benefits, from 69% in 2000 to 60% in 2005. This drop is driven largely by a significant decline in the percentage of small firms (3-199 workers) offering coverage, which has fallen from 68% to 59% over the

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imposes a new, unpredictable liability at random on those small businesses that provide health insurance, can only accelerate the trend toward loss of coverage, contrary to the desire of Congress.

D. Given the Exclusive Jurisdiction of the Federal Circuit, It Would Be Futile to Await a Conflict Among the Circuits.

Speaking for the business community, especially the small business community, we wish to underline the urgency of this case and the futility of awaiting a conflict among the circuits. As noted in the petition (Pet. at 17-18), respondents have a suitable means of vindicating their illegitimate claims for reimbursement without ever bringing an action in federal court which might expose them to the threat of an inconsistent decision. That is, respondents can and do rely on the Treasury Offset Program, which permits them to take the amount of their claim out of the employer's tax refund.

And if an employer should be motivated to sue for a refund, as petitioner did in this case, the Federal Circuit would have exclusive jurisdiction of the appeal, guaranteeing the same outcome.

In short, no further development of the issue can be expected. This Court's review of this case is the only hope that small business has of correcting this error and avoiding

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same period." The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, 2005 Summary of Findings" at 4 (2005). Cost is overwhelmingly cited as the reason. *Id.* at chart #11.

its inevitably debilitating effect on the willingness of small business to offer medical insurance.

CONCLUSION

In ERISA, Congress sought and achieved a balance between the rights of employees (and others) and the burdens on employers, recognizing that misguided regulation could easily go overboard and, ironically, lead to the elimination of employee benefit plans. This Court has repeatedly upheld the balance that Congress achieved in ERISA against those who would upset it by imposing additional burdens on employers, and the time has come to do so again by granting *certiorari* in this case – a case that threatens the backbone of the private system of medical insurance, namely, small business.

Respectfully submitted,

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IN THE
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TELECARE CORP.,
Petitioner,

v.

MIKE LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF HEALTH AND HUMAN SERVICES; and CENTER FOR MEDICARE AND MEDICAID SERVICES,
Respondents.

On Petition for Writ of Certiorari
to the Court of Appeals for the Federal Circuit

REPLY BRIEF FOR PETITIONER

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42 C.F.R. § 411.24(e) 2

Other authority:

Routh, Paul J., Benefits Guide: Health Plans and Other Employer Sponsored Benefits § 3:22 (Nov. 2005 database update) 5

REPLY BRIEF FOR PETITIONER

The government does not dispute that, prior to the Federal Circuit's decision in this case, federal courts of appeals uniformly agreed that the government could invoke the MSP statute only against employers that were *contractually obligated* to pay for an individual's medical services. *See* Pet. for Cert. at 8-10 (citing cases from several federal circuits); Br. of Chamber of Commerce et al. as *Amici Curiae* (hereafter "Business *Amici*") at 13. Yet the government contends that the 2003 amendments to the MSP statute – which it acknowledges were enacted "to clarify rather than to change the law" (BIO at 5) – nevertheless effectuated a fundamental and profound change in Medicare law, creating a brand new system under which the government may require employers to pay for their employees' medical care even when employers bear no contractual financial responsibility whatsoever for those services. Under the government's view, Congress – without ever breathing a single word in a single hearing or report on the matter – intended in 2003 to transform a mere administrative "reimbursement" mechanism into a new system of liability that contravenes not just the prior conception of the MSP program but also, as the Business *Amici* explain, basic principles of ERISA law.

The government's argument – to borrow the D.C. Circuit's phrase from the only other time in which the government has advanced a similar position – is "a complete jumble." *Health Ins. Ass'n v. Shalala,* 23 F.3d 412, 417 (D.C. Cir. 1994). It cannot be that the 2003 amendments simultaneously did nothing at all and also transformed the MSP system fundamentally. Rather, the amendments can and should be treated as leaving in place the principle that the government may recover money from employers under the MSP statute only when those employers had a contractual obligation in the first instance to pay for a medical item or service. The Federal

Circuit's transformative decision to the contrary should be reviewed at once.

A. The 2003 Amendments To The MSP Statute Do Not Impose Non-contractual Liability On Employers.

The government asserts that any employer that sponsors or contributes to a group health plan is subject to the government's MSP recoupment power, "without regard to whether the [employer] was contractually . . . required to pay for the cost of medical care." BIO at 8.[1] This argument for extending the government's power beyond situations involving pre-existing contractual liability suffers from three major deficiencies.

1. The government is unable to give meaning to the MSP reimbursement statute's operative terms. An entity is subject to the government's MSP recoupment power only if it is "responsible . . . under a primary plan" for paying for the medical care at issue. 42 U.S.C. § 1395y(b)(2)(B)(iii). Yet the government never seriously engages with this language. The most it does is quickly assert at one point that, because employer plan contributions may lose their tax deductible status if third-party insurers illegally discriminate against Medicare recipients, employers that establish third-party insurance arrangements are "*responsible* for payment being made in a manner that comports with the requirements of the MSP statute." BIO at 3, 8 (emphasis added).

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[1] The government also suggests (BIO at 8) that a regulation that existed prior to the 2003 amendments, 42 C.F.R. § 411.24(e), interpreted the MSP statute this way. But the key language in the government's brief appears nowhere in that regulation. Nor had any court ever interpreted the regulation to mean what the government says here it meant. That is because the regulation simply said the same thing as the statute itself.

Not even the Federal Circuit accepted this argument for satisfying § 1395y(b)(2)(B)(iii)'s responsibility requirement, for it ignores that an entity is subject to the government's MSP recoupment power only if it is "responsible" – to repeat – "*under a primary plan*" for paying for the medical service at issue. 42 U.S.C. § 1395y(b)(2)(B)(iii) (emphasis added).[2] Employers such as Petitioner have no such responsibility *under a primary plan*. Indeed, the very purpose of third-party insurance arrangements is to create primary plans under which insurance companies bear sole responsibility for paying employees' medical bills. And such arrangements do not somehow "shift" financial responsibility to insurance companies or "relieve" employers of some responsibility to reimburse Medicare when Medicare pays for their employees' medical services. BIO at 8, 10. Employers do not have any responsibility in the first place to offer any medical plans to employees. *See, e.g., Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743 (2004) ("Nothing in ERISA requires employers to establish employee benefit plans."); *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 78 (1995) (same). Nor do employers have any pre-existing or default obligation to pay for employees' medical services that are covered by Medicare. Such an obligation arises only when an employer voluntarily decides to "bear[] the ultimate responsibility for satisfying those expenses." Business *Amici* Br. at 7.

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[2] Of course, the Federal Circuit tried to finesse the "responsibility" requirement in the MSP statutory language in a different way, asserting that the term "responsible" means "involving a degree of accountability." Pet. App. 16a. But, as Petitioner and the Business *Amici* have explained, this suggestion, even if true, does not support the Federal Circuit's holding. Employers who simply pay premiums to insurance companies have no degree of accountability whatsoever for their employees' medical bills. Pet. for Cert. at 11; Br. of Business *Amici* at 3 n.2. That is presumably why the government advances a different argument here instead of trying to defend the Federal Circuit's analysis on this point.

In short, the MSP statute's antidiscrimination provisions simply encourage employers to ensure that third-party insurers pay for employees' medical coverage on an equal basis. They do not impose any obligation on *non-insurers* actually to pay medical bills. *See Health Ins. Ass'n,* 23 F.3d at 427 (Henderson, J., concurring).

2. The government's suggestion that its position is necessary to give meaning to other statutory terms likewise fails to withstand scrutiny. The government posits that the Federal Circuit's transformation of the MSP program is necessary to give independent meaning to the statute's parenthetical indication that it reaches "an employer that sponsors or contributes to a group health plan." BIO at 9 (quoting § 1395y(b)(2)(B)(iii)). But the government's assertion (BIO at 9) that this quoted phrase would not be necessary to cover self-insuring governmental, non-profit or charitable employers simply does not follow from the statute's restrictive definition of self-insuring entities, which is limited to entities engaged in a "business, trade, or profession." 42 U.S.C. § 1395y(b)(2)(A).

Perhaps more important, the government does not even try to refute the Business *Amici*'s explanation that the quoted phrase also can be read independently to apply to all kinds of employers that purchase third-party insurance but "still bear ultimate financial responsibility for the benefits." Br. of Business *Amici* at 3-4. Given the ready availability of interpretations that give meaning to the quoted phrase and that are consistent with the longstanding conception of the MSP program – a conception the government itself acknowledges was not supposed to be altered in the 2003 amendments (BIO at 5) – the Federal Circuit should have adopted one.

3. The government's construction of the statute also is at loggerheads with its overriding purpose. Petitioner and the Business *Amici* have explained that imposing the new kind of

non-contractual MSP liability the Federal Circuit has created would push small employers to cease offering any medical plans to employees. Such repeals of coverage would shift those expenses – contrary to the cost-cutting purpose of the MSP program – solely to Medicare. Pet. for Cert. at 2, 16; Business *Amici* at 15-16. The government responds that this is immaterial because "small employers are exempt from the statute's requirements." BIO at 9. Yet the statute exempts only those businesses with fewer than twenty employees. 42 U.S.C. § 1395y(b)(1)(A)(ii). The legion of small businesses with twenty or more employees would face exactly the perverse choice Petitioner has described.

The government also insists that employers that sponsor or contribute to health plans can protect themselves from liability either by persuading their insurance carriers always to reimburse Medicare directly (even if outside of the customary one-year period for submitting claims) or by negotiating indemnity provisions. BIO at 10. "Although this advice . . . may sound good, as a practical matter, most carriers simply will not amend their contracts" to cover claims outside of standard contractual limitations periods. Paul J. Routh, Welfare Benefits Guide: Health Plans and Other Employer Sponsored Benefits § 3:22 (Nov. 2005 database update) (commenting on Federal Circuit's decision here). And it blinks reality to suggest that small or even big businesses will be able to extract indemnity provisions from third-party insurers. The government does not provide any evidence that any employer has ever done so, and Petitioner is not aware of any either.

B. This Court Should Review This Issue Without Delay.

The government does not dispute the importance of the question presented, but it urges this Court to delay review for two reasons. Neither withstands scrutiny.

1. The government states that the Federal Circuit's decision is the first appellate decision to interpret the 2003 amendments and suggests that it does not conflict with the decisions Petitioner cites (Pet. for Cert. at 9-10) because those decisions "were decided before Congress enacted the 2003 amendments." BIO at 10. Yet, as the government acknowledges elsewhere, "Congress formally declared that the amendments were 'clarifying,' 117 Stat. 2221," and were not "intended . . . to change the law." BIO at 5. Accordingly, the fact that the Federal Circuit's decision disagrees with prior uniform precedent to hold that the MSP statute goes beyond contractual obligations to create new liability is highly relevant, deeply troubling, and worthy of prompt review.

2. Although the government does not dispute that any future case an employer brings respecting the question presented will flow to the Federal Circuit, it asserts that further percolation may still prove useful because future cases may arise in other circuits if (a) the government sues employers who are not subject to the treasury offset program or (b) private parties initiate private cases against other private parties. BIO at 11-12. Neither hypothetical scenario, however, supports the government's assertion.

First, the government does not point to a single actual case – either before or after the 2003 amendments – in which it has sued an employer under the MSP statute for the cost of an individual employee's medical bills. Nor is Petitioner aware of any. This is hardly surprising, since the treasury offset program is almost always available, and when it is not, the

government uses other heavy handed collection methods to get the money it wants. In its demand letters, the government tells employers that a failure to pay may result in the government disqualifying the employer's plan, thereby subjecting all the employer's contributions to taxation. The government also threatens to seek double damages from employers, as provided in 42 U.S.C. § 1395y(b)(2)(B)(iii). Pet. App. 49a. Thus, in order for an employer to oppose the government's position in a manner that would subject it to appellate litigation outside of the Federal Circuit, an employer would have to risk significant penalties that go well beyond the amount at issue. Apparently no employer ever has been willing to do so with respect to a dollar amount that the government thought was worth pursuing by filing suit.

Second, any private cause of action a party initiates will not squarely raise the question presented because it would involve a different statutory provision than is at issue here. The private action provision requires lawsuits to be brought when "a primary plan fails to pay," 42 U.S.C. § 1395y(b)(3)(A); it does not give private parties the power – as the government says it has in the statute at issue here – to sue an entity, other than a plan, that bears no contractual responsibility to pay for a medical service. BIO at 8. Even if the government were correct that employers that sponsor third-party insurance are somehow "responsible" under § 1395y(b)(2)(B)(iii) to pay for medical services, it would be a different matter to say that such employers are plans themselves, as would be required in the context of a private lawsuit.

Accordingly, this Court should use this case to review the question presented, as it is highly unlikely that another suitable vehicle will arise anytime soon, if at all.

CONCLUSION

For the foregoing reasons, as well as those stated in the petition for certiorari, the petition for writ of certiorari should be granted.

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